**Issue Date: 20 December 2002U.S. Department of Labor** Office of Administrative Law Judges
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In the Matter of

EDMUNDO R. VILLANUEVA
Claimant

Case No.: 2001 LHC 2139

v.

OWCP No.: 08-112605

PORT COOPER/T. SMITH STEVEDORING
Employer
and
C. T. STEVEDORING, INC.
Insurer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

APPEARANCES: Mr. Harry C. Arthur, Attorney
For the Claimant

Mr. Michael D. Williams, Attorney
For the Employer

BEFORE: Richard T. Stansell-Gamm
Administrative Law Judge

**DECISION AND ORDER -**
**AWARD OF MEDICAL TREATMENT**
**AWARD OF TEMPORARY TOTAL DISABILITY COMPENSATION**

This case involves a claim filed by Mr. Edmundo Villanueva for benefits and medical treatment under the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. §§ 901 - 950, as amended ("the Act") in January 1999. The claim stems from an accident which occurred on April 6, 1997 while Mr. Villanueva was working for Port Cooper in Houston, Texas.

On May 9, 2001, the District Director forwarded to the Office of Administrative Law Judges the pre-hearing statements filed by the Claimant's counsel. Pursuant to a Notice of Hearing, dated

July 23, 2001 (ALJ I),[1] I conducted a formal hearing on December 6, 2001, in Houston, Texas, attended by Mr. Villanueva, Mr. Arthur and Mr. Williams. My decision in this case is based on the testimony presented at the hearing and all the documents admitted into evidence: CX 1 to CX 34 and EX 1 to EX 23.[2]

## Procedural Issue

At the start of the hearing, counsel for the Employer objected to consideration of any issue other than authorization of back surgery on the basis that no other issue was considered by the District Director. He also requested a remand (TR, pages 7, 8, and 16). In support of his argument, Mr. Williams noted that the parties only discussed the requested back surgery at the District Director's informal conference. Since then the Claimant has raised issues concerning the nature and extent of disability. After I observed that LS-18 filed by Claimant's counsel in May 2001 listed medical treatment and nature and extent of disability as issues, Mr. Arthur explained that following the informal conference, and prior to the filing of the LS-18, the Employer stopped its voluntary compensation payments to Mr. Villanueva. As a result, he added nature and extent of disability on the LS-18 (TR, pages 11 to 13). Since the parties seemed to have developed evidence concerning all the issues and Mr. Arthur indicated that he did not want to further delay the proceeding just to preserve his ability to obtain a full attorney fee (TR, page 15), I denied the Employer's request for a remand (TR, page 16).

## Issues

1. Causation

2. Medical Treatment, Maximum Medical Improvement, and Nature of Disability

3. Extent of Disability

4. Attorney Fees

## Parties' Positions

[1] The following notations appear in this decision to identify specific evidence and other documents: ALJ - Administrative Law Judge exhibit, CX - Claimant exhibit, EX - Employer exhibit, and TR - Transcript of hearing. CX 35, offered but not admitted, is attached to the record.

[2] I admitted EX 1 to EX 20 at the hearing. Due to several discovery issues, I provided Mr. Williams the opportunity to present additional evidence post-hearing (*See* TR, pages 36 to 42). Subsequently, I received three additional items, which I have marked EX 21 to EX 23 and now admit into evidence.

Claimant[3]

Mr. Villanueva injured his low back in the April 6, 1997 accident. The causation is established by his testimony, medical opinion and the operation of the presumption under Section 20 (a) of the Act. Further, in light of the more probative medical opinion, the Employer has failed to rebut the presumption. Due to his work-related low back injury, and again established by the more probative medical opinions, Mr. Villanueva now requires a surgery as a reasonable and necessary treatment. In light of the necessity of surgery, Mr. Villanueva has not reached maximum medical improvement. Consequently, the nature of his corresponding disability is temporary. Finally, due to the pain associated with his untreated low back injury, Mr. Villanueva has been unable to return to employment which renders the extent of his disability as total.

Employer[4]

Mr. Villanueva' present low back condition was not caused by his April 6, 1997 accident. Based on the reported circumstances of his accident on April 6, 1997, the absence of contemporaneous complaints of low back pain, and the more probative medical opinion, Mr. Villanueva has failed to establish the requisite *prima facie* case to invoke the causation presumption under Section 20 (a). Even if his low back condition were related to his accident, back surgery is not a reasonable and necessary medical treatment since the more probative medical opinions indicate such a procedure is not warranted. Since no further medical treatment is appropriate, Mr. Villanueva has also reached maximum medical improvement. Physicians have released him to return to his former employment as a longshoreman without restrictions, suitable alternative employment has been established, and Mr. Villanueva has failed to show reasonable diligence in seeking employment. Consequently, Mr. Villanueva is not disabled under the Act. Finally, even if Mr. Villanueva receives a favorable determination on the issues of nature and extent of disability, the Employer is not responsible for the Claimant's attorney fee because the requirements of Section 28 of the Act have not been satisfied. In particular, Employer voluntarily paid compensation benefits and counsel for the Claimant did not present the issues relating to disability at the informal conference with the District Director, which addressed only the need for further medical treatment.

## Summary of Evidence

While I have read and considered all the evidence presented, I will only summarize below the information potentially relevant in addressing the issues.

## Sworn Testimony for Claimant

Mr. Edmundo Villanueva

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[3]Hearing statements (TR, pages 6, 7, and 50 to 53) and closing brief, dated February 25, 2002.

[4]Hearing statements (TR, pages 7 and 8) and closing brief, dated February 22, 2002.

(TR, pages 54 to 93)

[Direct Examination] Born on November 20, 1946, Mr. Edmundo Villanueva is 55 years old. Until two months prior to the hearing, he lived in a house in Houston, Texas. He has since moved to LaPorte, Texas to live with his son, who has been assisting him for about ten months since his compensation stopped.

Mr. Villanueva completed 5th grade and went to work as a migrant farmer to help his family of 14. He is able to read with some difficulty. Mr. Villanueva moved to Houston, Texas in the early 1960s and worked construction in various jobs. He first started work in the shipyards around 1968 or 1969. In 1990, while working as a sandblaster and painter for Mopley Industrial Painters, Mr. Villanueva suffered a work-related accident. While painting the side of a ship, he stepped on a pipe which broke, causing him to fall and be suspended 130 feet above the ground by his safety belt. The accident caused an injury to his back and Mr. Villanueva was out of work for a year during recovery. When he returned to work, he felt good and continued to work for the next several years without any problems. He moved to Maryland as a member of a longshoreman union and continued industrial sandblasting and painting. In November 1996, Mr. Villanueva returned to the Houston area because Maryland was too cold and the weather bothered his arthritis. He resumed his work as a longshoreman with a classification of number three. Due to that classification, his typical work occurred in inside the hull moving heavy bags and lifting heavy steel.

On April 6, 1997, Mr. Villanueva hired out to be at work at 7:00 a.m. About two and a half hours later, he was helping load heavy rolls of paper onto a ship. To lift the rolls, the crane used suction lifters. When Mr. Villanueva checked to see if the lifters were fastened, the crane operator, without apparently seeing him, open the lifters which kicked Mr. Villanueva against the ship. He hit his head and left shoulder against the ship, then landed on his hand and elbow. His back started hurting. After he shook himself down, Mr. Villanueva returned to work. However, after an hour, he informed the timekeeper that he needed to see a doctor and he got a referral. Upon arrival at the Pasadena Memorial Hospital, he was treated and informed nothing was wrong. Yet, when Mr. Villanueva couldn't get out of bed the next morning, he decided to see Dr. Guerrero based on his roommate's recommendation.

Dr. Guerrero conducted some tests, diagnosed a bad shoulder and provided some therapy. Mr. Villanueva then saw Dr. Sanders who recommended low back and shoulder surgery. Dr. Moseley successfully operated on his shoulder and it doesn't bother him anymore. Dr. Lazarz and Dr. Bindal have also recommended low back surgery. Mr. Villanueva believes he needs the operation because he can't stand the pain anymore and wants to get back to work.

After his injury, Mr. Villanueva attempted to go back to work as a restaurant dishwasher but the job lasted only a week. The restaurant floors were slippery and Mr. Villanueva was not able to keep up with the expected pace. He also had problems getting to work because he slept late due to fatigue and medication. Mr. Villanueva also tried work as a tile setter and helper. The job required him to lift and carry 20 pound boxes of tile. He worked for about two months but was slow and absent frequently. When Mr. Villanueva tried to return to sandblasting and painting, he lasted three

days. He was fired because he couldn't handle the high pressure hose and had to take breaks all the time. Mr. Villanueva was also employed briefly with a temporary labor company, Minuteman. He worked a sweeper and lasted a month. The company fired him when they found out about his bad back.

A few years ago, Mr. Villanueva met Mr. Quintanilla but hasn't seen him since then.

Mr. Villanueva has worked as a foreman. But, in sandblasting and painting, even a foreman has to paint, and at times, climb and run. He is not able to climb and can "barely walk." Additionally, a foreman handles paper work but Mr. Villanueva can't read or write.

Mr. Villanueva does not believe he is presently capable of any work. When he tries to do any house activity, like cleaning, he can only last about 20 to 30 minutes. He gets up early each morning due to pain. Then, he spends most of his day sitting. He lives with his son, who is also a sandblaster, and cooks some but they eat mostly snacks and cold cuts. They sit around and watch TV and usually go to bed around 9 at night. Mr. Villanueva takes aspirin, Tylenol, and Advil for pain.

In addition to his back problems, Mr. Villanueva has high blood pressure, diabetes, and a thyroid problem. Before he lost his compensation, Mr. Villanueva used to rent a house and own a car. Now, his son supports him.

[Cross Examination] When he fell on April 6, 1997, Mr. Villanueva struck his head and caught himself with his left shoulder and arm. His back hurt then and he tried to tell the doctors. But, they only wanted to concentrate on one thing at a time so they first focused on his head and shoulder. Later, they considered his back condition. When he went to the emergency room on the day of the accident, he told them about his back. He also told Dr. Guerrero about his back.

Mr. Villanueva has not informed the doctor treating him for high blood pressure and diabetes about shooting pains in his legs.

He attempted all the jobs previously described prior to his shoulder operation. Since his shoulder operation, Mr. Villanueva has not worked. Once, he did look for work where his son was employed but nowhere else. He has a driver's license.

Mr. Villanueva has applied for Social Security.

After his back surgery in 1990 or 1991, Mr. Villanueva did not have any problems with his legs or back. He had no symptoms of pain and was able to do his work.

[Redirect Examination] Mr. Villanueva takes medication for his blood pressure, thyroid condition, and diabetes. The medication keeps those problems under control. Those health issues do not prevent his return to work. If his back were better, Mr. Villanueva would return to work. Only one company has "run" him off due to his medications.

He applied for Social Security because his compensation had been cut off.

[ALJ Examination] Mr. Villanueva experiences low pain back located just above his belt line. When he fell in 1990, the safety belt caught him when he fell.

Mr. Villanueva can not return to his prior work as a longshoreman because the work is hard. According to Mr. Villanueva, "There no such thing as light duty as a longshoreman." Presently, he can only lift a shoe shine box. He has applied for disability benefits due to his back problems.

**Claimant's Documentary Evidence**

Dr. Jorge Guerrero
CX 2 and CX 19

On April 8, 1997, Dr. Guerrero examined Mr. Villanueva who reported that a machine at work knocked him down, causing him to hit his head, left shoulder, left elbow and left wrist. Mr. Villaneuva complained about headaches but was not in acute distress. Dr. Guerrero recorded no prior surgery history. Upon examination of the left upper extremeties, Dr. Guerrero found tenderness to touch in the left shouder, wrist and elbow. The physician prescribed anti-inflammatory medication and rehabilitation therapy to relieve discomfort. He also ordered x-rays for Mr. Villanueva's skull, left shoulder, left elbow, and left wrist. Dr. Guerrero diagnosed cervical, elbow, and wrist strain, and possible closed head injury. He took Mr. Villanueva off work.

During an April 14, 1997 follow-up visit, Mr. Villanueva reported continued pain which increased with activity. Physical examination verified the pain. Dr. Guerrero continued with his original diagnosis. In addition to the previously prescribed medication and therapy, Dr. Guerrero recommended both a cervical MRI and a lumbar CT scan.

Ten days later, April 24, 1997, Dr. Guerrero found essential the same presentation. Mr. Villanueva had a history of left shoulder, elbow, and wrist pain. He continued to complain about headaches. Dr. Guerrero renewed his recommendation for an MRI and a lumber CT scan.

On May 1, 1997, Dr. Guerrero reported that Mr. Villanueva had "continued pain to left shoulder area, neck and low back." Due to increased pain, he was unable to walk up or down stairs. Dr. Guerrero reported limited range of neck motion. Examination of the lumbosacral area revealed positive results at 45 degree leg lifts, bilaterally. Flexing of the toes, tiptoeing and heel walking also caused increased low back pain. The left shoulder, elbow and wrist continued to be tender. Following this examination, Dr. Guerrero diagnosed cervical and lumbar radiculopathy, and left shoulder and elbow strain. He requested an MRI study of the left shoulder and an EMG to assess any root compression or nerve damage. Dr. Guerrero also mentioned that a cervical myleogram was positive for disc disease at C3-4, C4-5, C5-6, and C6-7. Additionally, the lumbar CT scan was positive for a hernia at L3-L4. Mr. Villanueva remained unable to work.

A May 15, 1997 examination produced the same findings. Mr. Villanueva indicated that he could not walk, stand or sit for prolonged periods due to increased pain in the lumbarsacral area. In addition, shoulder pain precluded overhead lifting. Physical examination verified the low back and left shoulder pain. Dr. Guerrero's diagnosis remained the same.

After a May 22 1997 examination produced the same results and diagnosis, Dr. Guerrero also recommended a lumber myelogram due to the positive CT scan of the lumbar area. A June 5, 1997 examination produced the same findings and recommendation. Dr. Guerrero also reported to the Employer a diagnosis of cervical and lumbar radioculpathy, left shoulder injury, left elbow sprain and possible closed head injury. He could not estimate when Mr. Villanueva might return to work.

Between April 9, 1997 through June 2, 1997, Mr. Villanueva received physical therapy to relieve muscle spasms and tenderness in his cervical area, left shoulder, left elbow, and left wrist. Of the nearly 20 entries concerning this treatment, only one therapy note, dated May 16, 1997, indicates Mr. Villanueva is presenting with cervical and lumbar strain. The remaining notes only mention cervical sprain and the left upper extremities. At most of the visits, Mr. Villanueva reported no change in his conditions.

After each follow-up examination on June 19, June 30, and July 14, 1997, Dr. Guerrero reported similar complaints, findings, diagnoses and recommendations. The physician also observed that the insurance dispute was forcing Mr. Villanueva to remain on oral medication for his pain.

In comments following an August 1, 1997 examination, Dr. Guerrero stated his understanding that Mr. Villanueva had suffered a previous low back injury. However, the doctor also observed that Mr. Villanueva had been working well prior to the most recent accident. To clarify the issue, Dr. Guerrero again recommended additional tests for the lumbar area.

Dr. Guerrero continued to conduct follow-up examinations of Mr. Villanueva on August 8, August 29, and September 12, 1997 with no change in status. Dr. Guerrero further suggested an MRI with contrast. An exam on October 3, 1997 indicated increased tenderness upon palpitation of the L4-L5 and L5-S1 areas. Dr. Guerrero also concurred with Dr. Sanders' recommendation of spinal surgery and shoulder arthroscopy for Mr. Villanueva.

Dr. Guerrero continued his periodic examinations and reports on October 17, October 31, November 24, December1997, and January 12, February 10, February 24, April 4, and July 1, 1998. By mid-October, 1997, the persistent diagnosis was cervical radiculopathy (nerve root disease or compression[5]), lumbar radiculopathy, and left shoulder internal derangement. At mid-December, Dr. Guerrero recommended a lumbar brace for Mr. Villanueva. In January 1998, Dr. Guerrero increased Mr. Villanueva's pain medication. By April 1998, the sole remaining diagnosis was lumbar radiculopathy. Dr. Guerrero continued to stress the need to proceed with the recommended tests and treatment.

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[5]DORLAND'S ILLUSTRATED MEDICAL DICTIONARY (28th ed. 1994), page 1404.

Dr. S. Kahkeshani
CX 3

On October 9, 1997, Dr. Kahkeshani examined Mr. Villanueva for intermittent, localized headaches. Mr. Villanueva had suffered an accident at work that caused him to strike his head, rear of his neck, left shoulder, and left arm. Mr. Villanueva presented pain complaints concerning his left shoulder, left arm, left wrist, and low back. Upon examination, Dr. Kahkeshani found the cervical area tender and was able to precipitation the headaches by applying pressure on a nerve. The doctor diagnosed occipital neuralgia which he anticipated would resolve over time. On November 11, November 25, 1997, and January 6, 1998, Dr. Kahkeshani applied nerve blocks to relieve Mr. Villanueva's headaches.

Dr. Bruce Moseley
CX 4, EX 16, EX 16, and EX 17

On May 12, 1997, Dr. Moseley evaluated Mr. Villanueva's reported injuries to his left shoulder, left elbow, left wrist, neck and head. Mr. Villanueva did not present any back pain complaints. Upon examination, Mr. Villanueva showed only soreness in neck and pain in the left shoulder. The x-rays and range of motion of the elbow and wrist were normal. While he did not conduct a formal back examination, Dr. Moseley observed that Mr. Villanueva demonstrated no mobility problems. This seemed remarkable because an MRI revealed a herniated disc. Dr. Moseley diagnosed blunt trauma to multiple areas and recommended a joint MRI and a neurological referral. If these two exams were normal, Dr. Moseley anticipated Mr. Villanueva could return to work in two months.

On February 8, 1999, Dr. Moseley focused only on Mr. Villanueva's left shoulder. His physical examination was consistent with Mr. Villanueva's very specific shoulder complaints, which contrasted to his prior complaints of pain in multiple areas which produced non-specific findings. Dr. Moseley diagnosed left shoulder impingement and recommended surgery. Mr. Villanueva had not reached maximum medical improvement ("MMI") and could not return to full employment. In that regard, Dr. Moseley observed that Mr. Villanueva still complained about back pain.

Following shoulder surgery, Dr. Moseley reported on October 11, 1999 that Mr. Villanueva was recovering nicely. He recommended home exercise and indicated Mr. Villanueva could do whatever he felt up to work-wise in regard to his shoulder. In response, Mr. Villanueva reported that he was unable to work due to his back. Dr. Moseley indicate no further treatment was necessary for his shoulder.

Employer's Interrogatory Response and Supervisor Report
CX 5

In July 1998, the Employer indicated that the Claimant's request for the name of any rehabilitation expert the Employer intended to call was "not applicable." Attached to the

interrogatory responses was a report by Mr. Dennis Maurice, a supervisor, about Mr. Villanueva's accident. According to Mr. Maurice, on April 6, 1997, around 8:45 a.m,. Mr. Villanueva was checking the position of air valves when the crane operator lowered all four flipper arms and then raised them causing a flipper to strike Mr. Villanueva. He was struck in the chest and knocked between the dock and the ship. He suffered injuries to his left wrist, left elbow, left shoulder and had a bump on the left side of his head.

Mr. Villanueva's Interrogatory Answers
CX 6

In August 1998, in his answers to the Employer's interrogatories, Mr. Villanueva indicated that he injured his left shoulder, left elbow, left wrist, low back and neck in this accident. He reported a previous on-the-job injury to his back in 1990 with Mobile Industrial Painters. At that time, he was treated by Dr. Kaldis. As post-accident employment, Mr. Villanueva listed National Tile and Terrazzo from February 1998 at $8.00 an hour and Minute Man of America for one month at $5.15 an hour. He also worked one week in July 1998 as a dishwasher and two days as a painter. He was denied employment due a failed drug screen which showed the presence of prescription medicine.

EMG Test Report
CX 7

A EMG conducted May 7, 1997 showed some slowing of the nerve impulses. The report recommended conservative therapy.

Dr. Joon S. Lee
CX 8, CX 9 ,CX 31, and CX 34

On April 21, 1997 and July 24, 1997, Dr. Lee, board certified in diagnostic radiology, interpreted a lumbar CT scan, lumbar myleogram and high resolution CT scan of Mr. Villanueva's spine. All three tests produced similar results. At L3-L4, a large 8 to 10 mm diffuse herniated disc is present, mostly left, with severe diffuse compression and severe central spinal stenosis (narrowing of the vertebral canal[6]). At L4-L5, along with post-operative changes, previous laminectomy and bony graft, a recurrent 4 to 5 mm partial calcified herniated disc is present. And, images at L5-S1, disclosed post operative changes, a previous laminectomy with bony graft, and a 3 mm broad base diffuse, recurrent bulging disc exists.

A July 9,1997 lumbar spine MRI showed evidence of left-sided partial laminectomy at L4-L5 with postoperative changes consisting of 5 mm recurrent herniated disc; moderate to moderately advanced spondylosis with degeneration of the discs at L3-L4, L4-L5, and L-5-S1; an 8mm large diffuse herniated disc at L3-L4 posteriorly with a diffuse anterior bulged disc.

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[6] *Id.* at page 1576.

A cervical MRI in April 1997 indicated the presence of degenerative disc disease, a 2 mm bulging discs at C2-3 and C5-6, and a 2.5mm herniated disc at C3-4

MRIs of the left shoulder in May 1997 showed tendinitis with no tear, bursitis and moderate osteoarthritic changes in a joint.

Dr. Mark S. Sanders
CX 10 and CX 18

Based on Dr. Guerrero's referral, Dr. Sanders, board certified in orthopaedic and neurological surgery, examined Mr. Villanueva on September 25, 1997. Mr. Villanueva reported a work-related injury on April 6, 1997 to his low back, left shoulder, and left elbow. He experienced ongoing pain in his shoulder and low back which radiated down to his thigh. Mr. Villanueva also reported a prior lumbar disc surgery in 1994. Upon examination of the shoulder, Dr. Sanders found muscle atrophy, some limitation in range of motion and tenderness. The examination of the elbow, wrist and hand were normal. Examination of the low back revealed a healed surgical scar, positive straight leg lifts and some reduced quadriceps strength on the left side. Dr. Sanders also reviewed the MRIs, CAT scan, and mylegrams. He concluded Mr. Villanueva might have a rotator cuff tear and impingement in his left shoulder. Dr. Sanders also opined Mr. Villanueva has a previous hemi-laminectomy at L4-L5, and a sequestered disc and fragment at L3-L4. The most severe problem was the 8 mm herniated disc at L3-L4. In light of these findings, Dr. Sanders believed Mr. Villanueva needed low back surgery and arthroscopic surgery on his left shoulder.

On July 28, 1998, Dr. Sanders again examined Mr. Villanueva and reiterated his opinion that he needed arthroscopic shoulder surgery and lumbar disc surgery. In August 1998, Dr. Sanders completed a work restriction evaluation indicating Mr. Villanueva could not lift more than 20 pounds and could not climb, bend, kneel, or twist. According to the physician, he was not capable of working an eight hour day until he had lumbar and shoulder surgery. After such surgery, Mr. Villanueva would need eight months to recover. As a result, he was not at maximum medical improvement.

Mr. Villanueva's Compensation Claim
CX 11 and EX 2

On June 17, 1997, Mr. Villanueva filed a disability compensation claim under the Act for injuries he suffered at work on April 6, 1997. The affected areas included his neck, left arm, elbow, left shoulder, wrist, "and other parts of my body."

1997 Income
CX 12

In 1997, Mr. Villanueva's W-2 covered the following income:

| | | |
|---|---|---|
| American Stone Company | - | $776.00 |
| Associate Building | - | $128.75 |
| Pappas Partners | - | $43.21 |
| Boggs & Tatum | - | (unreadable) |

Mr. Edmundo Villanueva's Deposition
CX 16

In a deposition taken June 29, 1998, Mr. Villanueva described his April 6, 1997 accident. As he was checking the valves on some lifters, the crane operator raised a lifter throwing him between the ship and the dock. He hit his head and shoulder and landed on his elbow and wrist. Mr. Villanueva went to Dr. Guerrero who prescribed medication and physical therapy. The doctor told him that he had a bad disc[7] and left shoulder problems. Although he no longer had headaches, he still took pain medication and had problems with pressure on his elbow. The pain in his shoulder restricted his activities. Every once in a while he also experiences neck pain.

He tried working a few days in January 1998 as janitor but had to quit because he was hurting due to all the stooping. Starting in February 1998, he also worked about two and a half months for a tile company. But that job as tile-setter helper hurt him due to the lifting requirment. At the time of the deposition, he had worked for a sandblasting company, Southwest Associate Painters, about three days, earning $11.00 an hour and then was fired because he couldn't do the work.

In 1990, while working for Mobley Industrial Painters, Mr. Villanueva stepped on a pipe which broke causing him to fall and hang 120 feet in the air by his safety belt. He didn't go to the emergency room but Dr. Kaldis eventually treated him and performed the back surgery. Mr. Villanueva also had right knee surgery in 1993. He has had no other injuries in the prior 10 to 15 years.

After the 1990 back surgery and prior to the 1997 accident, Mr. Villanueva had not experienced any back pain. He believes that he had fully recovered. He didn't have any problems with the stenuous work.

Report of Earnings - 1998
CX 17 and EX 7

On August 24, 1998, Mr. Villanueva reported earnings in 1998 from Pappas Restaurant ($206), Minute Man ($824), National Tile and Terrazzo ($4,027), Apache Industrial Painters ($324), and Southwest Associates ($319). He also received $2,093.00 in compensation from the Texas Workforce Commission.

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[7]Mr. Villanueva believed he had prior surgery on L3 and that the bad disc was L5. However, in light of Dr. Sanders' evaluation and the CT scan, Mr. Villanueva clearly was confused and reversed the identification.

Earnings Report - 1996 and 1997
CX 20

Between April 1996 and April 1997, Mr. Villanueva earned nearly $27,000 as a longshoreman.

Dr. Donald T. Lazarz
CX 21 and CX 22

On September 27, 1999, Dr. Lazarz, a board certified orthopaedic surgeon, examined Mr. Villanueva. At that time, Mr. Villanueva reported that he had been hurt in an accident on April 6, 1997 when a hydraulic lifter hit him in the stomach, forcing him into a wall. He suffered injuries to his back, neck and left shoulder. Since then, Mr. Villanueva has undergone MRIs of his cervical spine and left shoulder, a lumbar myleogram with CT scan of his lumbar area and an EMG. On July 6, 1999, Mr. Villanueva had surgery on his left shoulder and was still in physical therapy. He registered complaints of pain in his left shoulder, neck and low back with radiating pain and left leg numbness. Mr. Villanueva also reported prior lumbar surgery in 1990.

Upon examination, Dr. Lazarz found Mr. Villanueva had limited range of motion of his cervical spine, left shoulder and lumbar region. Dr. Lazarz also found muscle spasm in the lumbar area and numbness in the left great toe. An x-ray of the cervical spine did not disclose any significant disc disease. The x-ray of the lumbar area revealed a fusion mass at L5 to S1 and motion at L4-L5. Dr. Lazarz did not recommend neck surgery and believed the shoulder surgery was adequate. Concerning the low back, Dr. Lazarz said he had a report "indicating an 8 to 10 mm rupture at L3 and further problems at L4." The physician needed to know "whether or not the patient had a fusion that extends up to L4." Low back surgery was warranted but Dr. Lazarz was not certain of the exact level until he received records about the prior back surgery.

When Dr. Lazarz saw Mr. Villanueva again on March 27, 2000, he had continued back pain. Examination showed limited forward flexion and lateral motion. He also found muscle spasms with lumbar tenderness. Dr. Lazarz again recommended back surgery with spinal fusion as a possibility. However, he still needed to see the medical record from Dr. Kaldis about the earlier back surgery.

During a May 8, 2000 follow-up visit, Mr. Villanueva still had back pain. Examination revealed the same symptoms. Dr. Lazarz still did not have any information about the earlier back surgery.

In January 2001, Mr. Villanueva presented with continued low back pain and leg spasms. In addition to the previous symptoms, Dr. Lazarz also observed muscle decrease in the thighs and some sensory deficits in the legs. Dr. Lazarz had reviewed Dr. Lee's radiographic findings and considered the findings of Dr. Pennington (no compensable injury) and Dr. Brownhill. Dr. Lazarz believed Mr. Villanueva did have a compensable injury based on his examination and Dr. Lee's findings at L3. He

further explained that the L4 problem was probably related to the previous back surgery by Dr. Kaldis. If an additional MRI confirmed Dr. Lee's observations, Dr. Lazarz would recommend a lumbar laminectomy at L3.

Finally, on March 20, 2001, Dr. Lazarz again examined Mr. Villanueva, who reported symptomatic low back pain and radiating pain in his legs. A February 2001 MRI showed a lesion at L4, and due to a transitional vertebrae, he believed the lesion had been identified as L3 in a previous MRI. Dr. Lazarz recommend a lumbar laminectomy and Mr. Villanueva agreed.

Pre-Hearing Statement
CX 23

In a Pre-Hearing Statement, dated May 1, 2001, Mr. Arthur lists the following disputed issues: nature and extent of disability, permanency, maximum medical improvement, medical benefits, and average weekly wage.

Dr. Robert L. Brownhill
CX 24 and EX 13

Dr. Brownhill, a board certified orthopaedic surgeon, conducted a lumbar examination of Mr. Villanueva on November 9, 2000. Mr. Villanueva reported being struck by a hydraulic lifter and thrown against a wall in April 1997, causing multiple injuries, including his low back and left shoulder. Mr. Villanueva had corrective surgery to his shoulder and Dr. Lazarz had recommended spinal surgery. Mr. Villanueva indicated the constant presence of low back pain and left leg numbness. He also reported that he had a fusion in 1990 at L3.[8] Other medical problems included high blood pressure and diabetes. Dr. Brownhill reviewed the reports from Dr. Lazarz and Dr. Pennington, who concluded Mr. Villanueva had reached maximum medical improvement, did not need back surgery, and did not have a compensable injury.

Upon physical examination, Dr. Brownhill found no paraspinal muscle spasms. Mr. Villanueva did have tenderness over the mid lumbar spine. Although Mr. Villanueva demonstrated some limitation in lumbar flexion and extension, Dr. Brownhill felt the results were invalidated by the straight leg rises. Hip, leg, ankle and knee muscles appeared normal. And he walked without difficulty. Based on his evaluation, Dr. Brownhill diagnosed degenerative changes with the possibility of degenerative disc. He believed Mr. Villanueva's condition was post back surgery (1990). At the same time, he stated, "I do not have sufficient medical records to be specific about the condition of the back." In particular, Dr. Brownhill had not seen the radiographic films and tests. However, clinically, Mr. Villanueva "appeared to be doing reasonably well." Dr. Brownhill found no signs of radiculopathy but he probably had back pain due to a degenerative disc. According to Dr. Brownhill, Mr. Villanueva's problem was "related to the injury of April 6, 1997." At the same time, Dr. Brownhill did not recommend surgery.

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[8] *See* previous footnote.

Dr. Brownhill opined Mr. Villanueva could "probably" go back to work but without heavy lifting. At best, he should engage in medium work since he was a candidate for re-injury.

In December 2000, Dr. Brownhill reported a functional capacity evaluation had demonstrated Mr. Villanueva's capacity for medium work effort, or if unrestricted range of motion were required, light duty. Dr. Brownhill agreed with that assessment.

Functional Capacity Evaluation
CX 25 and EX 13

On November 13, 2000, Mr. Villanueva underwent a five hour functional capacity test. The evaluator concluded that in a restricted environment, Mr. Villanueva was capable of medium work (lifting up to 50 pounds). He needed periodic adjustments for posture change associated with sitting and standing. In an unrestricted workplace, he had the capacity for light work (lifting limited to 20 pounds). In the tests, Mr. Villanueva complained of pain in his low back during lifting and bending exercises and while climbing and walking.

Dr. Michael Kaldis
CX 26

Due to low back pain associated with an injury, an lumbar MRI study was conducted. On November 20, 1990, the tests revealed: mild degenerative spondylosisis present at L3 through S1; "marked spinal stenosis in an already congenitally narrowed spinal canal; disc degeneration at L3-L4 "with an associated anterior herniation as well as minimal postero central focal bulge with minimal impingement upon the left L3-L4 neural foramine;" and " a postero central herniation with anterior compression of the thecal sac" and marked compression due to changes of spinal stenosis. The diagnosis included disc herniation at L4-L5 and mild degenerative bulging L3-L4 with minimal encroachment on the left L3-L4 neural foramen. Additionally, anterior degenerative disc herniation was present at L3-L4.[9]

On February 12, 1991, Dr. Kaldis operated on Mr. Villanueva's low back at the L4-L5 level. During the procedure Dr. Kaldis identified a large protruding disc, which was removed. He also performed a laminectomy at L4 and on the inferior aspect of L5. Dr. Kaldis also reported a large component of stenosis in addition to the herniated disc.

Following a September 4, 1991 visit with Mr. Villanueva, Dr. Kaldis concluded he had reached maximum medical improvement and authorized his return to work with limited activity. Mr. Villanueva had a permanent partial impairment of 10% (whole body). Dr. Kaldis did not recommend

[9]This MRI report contained four "impressions" or diagnoses. The fourth diagnosis has been marked through on the document that was copied. However, it appears to reference a contained disc herniation at L3-L4. Since the main body of the report is not altered, I am still able to conclude that a degenerative disc herniation was also present at L3-L4.

Mr. Villanueva return to his former employment because it involved high climbing.

Dr. John F. McCluskey
CX 26

On January 17, 1992, Dr. McCluskey reported that Mr. Villanueva had been injured on October 19, 1990 when he slipped on a pipe and was left hanging by his safety belt. A November 1990 MRI revealed a central disc herniation at L4-L5 in addition to generalized spinal stenosis. On February 12, 1991, a lumbar laminectomy and disketomy were performed at L4-L5. Since the surgery, Mr. Villanueava has participated in physical therapy. His release to work included a restriction on high climbing. According to Mr. Villanueva, his physician indicated additional surgery may be needed in five years. Upon examination, Mr. Villanueva was in not acute distress and straight legs lifts appeared unremarkable.[10] Dr. McCluskey concluded Mr. Villanueva's impairment and loss of function was permanent.

Rehabilitation Assessment
CX 27 and CX 28

On November 19, 2001, Mr. Wallace Stanfill, a certified rehabilitation counselor, reported the results of Mr. Villanueva's rehabilitation assessment. In the evaluation, Mr. Stanfill first reviewed the extensive medical record developed since Mr. Villanueva's April 1997 accident. He also considered Mr. Villanueva's social, work, and limited educational histories.[11] At the time of the evaluation, Mr. Villanueva reported constant low back pain that radiated to his legs.

Based on Mr. Villanueva's union seniority at the time of the accident, he was only able to obtain work in the holds of ships which is considered very heavy labor. In a prior vocational report from 2000 and January 2001, the evaluator concluded based on the reports of Dr. Moseley, Dr. Pennington, and Dr. Brownhill that Mr. Villanueva did not have the physical capacity to return to his past longshore work as a sandblaster and painter. Instead, he could work as a sandblaster and painting foreman and in unskilled light work jobs.

After finding Dr. Pennington's evaluation too optimistic, Mr. Stanfill opined that Mr. Villanueva could not return to his prior work as a longshoreman. Further, because painting foreman are typically "working" foreman, he could not perform that task either.

Turning to the June 2000 labor market survey, Mr. Stanfill noted several jobs involving medium work which were not suitable and Mr. Villanueva did not possess the capacity for semi-

[10]An entire paragraph regarding the examination has been marked through on the document that was copied. However, some portions of the examination remain visible.

[11]Mr. Stanfill's testing confirmed Mr. Villanueva's limited educational background.

skilled labor, such as fork lift operator. Finally, the company with the security guard position was no longer in business.

Dr. Ajay K. Bindal
CX 29 and CX 30

On November 30, 2001, Dr. Bindal, board certified in neurological surgery, examined Mr. Villanueva since Dr. Lazarz was retiring. Dr. Bindal reviewed the extensive medical record and radiographic tests associated with Mr. Villanueva's back. Upon physical examination, Mr. Villanueva had pain in his lower back on movement, including bending and twisting. The physician also found some tenderness and muscle spasms. Upon review of the MRIs, Dr. Bindal observed herniated discs at L3-L4 and L4-L5 with evidence of a previous laminectomy at the L4-L5 level. Based on his reviews and examination, Dr. Bindal opined that Mr. Villanueva did have an injury to his back as a direct result of the April 6, 1997 accident. Further, Dr. Bindal believed he would benefit from a lumbar laminectomy at L3-L4 and L4-L5.

Dr. Linda L. Hankins
CX 33

On February 26, 2001, Dr. Hankins, board certified in diagnostic radiology and neuroradiology,[12] interpreted an MRI, with and without contrast, of Mr. Villanueva's lumbar spine. At L5-S1, she observed evidence of bilateral laminectomies and posterior spondylosis with moderate narrowing. At L4-L5, the physician reported a left paracentral disc protrusion measuring about 5 to 6 mm with indents the left ventral thecal sac, moderate bilateral narrowing. Dr. Hankins recommended correlation of her finding at L4-L5 with possible left radiculopathy. At L3-L4, mild loss of disc space existed.

**Employer's Documentary Evidence**

Notice of Informal Conference
EX 8

A June 15, 2000 Notice of Informal Conference indicates the issue to be addressed is medical treatment.

DOL Determination
EX 10

[12]I take judicial notice of Dr. Hankins' board certification and have attached the certification documentation. Since I did not advise the parties at a hearing of my intention to take judicial notice of the qualifications of physicians in this case, any party who objects to such judicial notice may enter a written objection within 10 days of the date of this decision, requesting my reconsideration of Dr. Hankins' medical qualifications.

On December 15, 2000, a DOL claims examiner informed the parties as follows::

> [I]t is the determination of this office that the claimant is entitled to reasonable and necessary medical treatment and diagnostic testing of lumbar spine as related to the original 4-6-97 injury, pursuant to Section 7 of the Act. Further, currently noninvasive, medical treatment should proceed at the direction of the treating physician pursuant to Section 7 of the Act.

Employer's Pre-Hearing Statement
EX 12

On May 30, 2001, Mr. Williams filed the Employer's pre-hearing statement indicating the issue to be addressed was reasonable and necessary medical treatment.

Dr. Jack W. Pennington
EX 14

On December 28, 1999, Dr. Pennington, board certified in orthopaedic surgery, evaluated Mr. Villanueva's condition. Mr. Villanueva reported being thrown at work and hitting his head and shoulder on the dock. He had constant pain in his low back and left thigh with numbness in the left great toe. He also reported a 1990 lumbar laminectomy. In addition to taking Mr. Villanueva's histories, Dr. Pennington also considered his medical record from 1997 and 1998 including the evaluations of Dr. Guerrero and Dr. Barrish and numerous MRIs, CT scans, and a myleogram. From these records, Dr. Pennington noted the absence of any low back pain complaints when Mr. Villanueva was treated at the emergency room right after the accident. The low back studies showed degenerative changes and arthritic changes consistent with Mr. Villanueva's age and postoperative changes. Additionally, he did not understand the basis for Dr. Guerrero's request for a lumbar CT scan.

During the examination, Dr. Pennington observed that Mr. Villanueva moved around without any problems and disrobed without discomfort. In the exam, Dr. Pennington did not find any acute problems with Mr. Villanueva's low back. According to Dr. Pennington, Mr. Villanueva had reached maximum medical improvement in regard to his shoulder, elbow and wrist. Concerning the low back, the physician did not see any clear history of a work-related injury or compensable injury. Even if his back condition were work-related, Dr. Pennington did not believe additional tests were necessary. He found Mr. Villanueva doing well and perhaps magnifying his symptoms. Dr. Pennington found no objective evidence that the April 1997 accident caused "any permanent injury or restriction of duties." Mr. Villanueva had reached his "preinjury status."

Dr. Pennington again examined Mr. Villanueva on April 24, 2000. At that time, Mr. Villanueva reported that he had shoulder surgery in July 1999 and that Dr. Lazarz had recommended back surgery at the number five disc level. Mr. Villanueva still had constant, midline, low back pain, with periodic shooting pains in his legs and numberness in both great toes. The later two symptoms

had been present since his 1990 surgery; however, he had been able to work until his April 1997 accident.

Dr. Pennington observed that Mr. Villanueva had no difficulty moving around the examination room, disrobing, or getting on the examination table. His lateral and bending movements were good, the straight leg lifts were negative and no neurological deficits were found. Dr. Pennington reviewed Dr. Lazarz's report but concluded there was no "clear" history of a "direct" work related injury. Consequently, Dr. Pennington did not believe Mr. Villanueva had a compensable back injury. He also recommended no further treatment, including surgery. Since the problems associated with Mr. Villanueva's shoulder, elbow, wrist, hand, neck and head had been resolved, he was at maximum medical improvement and capable of returning to his regular duties as a longshoreman.

Dr. J. Martin Barrash
EX 15 , EX 20, and EX 21

On July 1, 1997, Dr. Barrash, a board certified neurosurgeon, reviewed Mr. Villanueva's medical record and examined him. Mr. Villanueva reported that he had been knocked five feet by a crane lifter and hit his hard hat on the ground and landed on his left shoulder and elbow. At present, his low back was painful and he experienced numbness and cramps in his left leg. In 1990, Mr. Villanueva had back surgery and in 1994 and 1991, he received extensive medical treatment for two traumatic wounds.[13]

Upon examination of the low back, Dr. Barrash found no evidence of muscle spasms or atrophy. Mr. Villanueva did have decreased sensation in his left leg from the mid-thigh down. A plain x-ray showed spondylosis and a decompressive laminectomy at L5. However, in the absence of a mylegram and a lumbar CT scan, Dr. Barrash deferred a definitive diagnosis. At the same time, Dr. Barrash suggested that Mr. Villanueva's symptoms may be residual effects of this prior 1990 back surgery. In addition, Mr. Villanueva may be near maximum medical improvement. Once released to work, he probably won't have any residual effects.

On August 15, 1997, Dr. Barrash reported that he had reviewed the mylegram and CT scan of Mr. Villanueva's lumbar spine. He found the tests inadequate to a "clinical decision." Specifically, he "couldn't discern one way or the other whether this is residual or indeed new pathologic condition, since it is a postoperative study." Dr. Barrash still needed to see an MRI with contrast.

In October 2001, Dr. Barrash indicated that he had reviewed additional medical tests and stated a July 9, 1997 CT scan with contrast showed "the scar." He also re-examined Mr. Villanueva and observed continued sensation loss in the lower extremities. When raising his legs while sitting, he complained about low back pain. Mr. Villanueva was not a surgical candidate. Instead, his

[13]Based on other medical histories in the record, and Mr. Villanueva's deposition, I believe Dr. Barrash misstated the dates of these two injuries, which occurred in 1964 and 1971. *See* EX 14, CX 27, and CX 16, page 24.

problems were associated with adult onset and non-insulin dependent diabetes. He could return to work in light to, at most, medium duties.

In a November 20, 2001 deposition, Dr. Barrash reviewed the results of his July 1997 examination and reiterated his belief that the findings represented residual symptoms from the 1990 back surgery. After reviewing the 1997 radiographic evidence and myleogram, Dr. Barrash concluded they only showed postoperative changes and degenerative changes. He didn't think they showed "anything to suggest acute herniated disc or an acute problem." At the same time, he also requested an MRI of the area because a myleogram is "not a very good test in these postoperative backs." Dr. Barrash believed he eventually saw the MRI and that it showed scarring and the contrast revealed an additional scar. The radiographic evidence did not provide him a basis for concluding Mr. Villanueva suffered a new back injury in 1997. Dr. Barrash also observed that the accident occurred in April whereas Mr. Villanueva's first low back pain complaints were noted in June. He believed if someone injured his back, it would start bothering the person within a week or two and not a couple of months.

Dr. Barrash further disagreed with Dr. Lee's interpretations of the radiographic films. Examining the films, Dr. Barrash instead observed a scarred canal which the myleogram demonstrated was adequate. He also didn't see a left lateral defect on the sac at L3-L4 that Dr. Lee described. According to Dr. Barrash, there is no large defuse herniated disc. Dr. Lee also reported an 8 mm large diffused-type herinated disc to the left on the CT scan interpretation, but Dr. Barrash didn't see it in the x-ray. All he observed was postoperative scarring. Dr. Barrash also expressed professional disagreement in general with Dr. Lee's interpretations based on his past experiences with the radiologist. Mr. Villanueva's present back condition pre-existed the April 1997 incident. In the October 2001 physical exam, Dr. Barrash also noted Mr. Villanueva had improved flexion.

Dr. Barrash remains convinced Mr. Villanueva is not a candidate for back surgery for several reasons. First, Mr. Villanueva doesn't have any clinical symptoms of a significant abnormality. Second, the radiographic evidence shows postoperative changes from the ten year old surgery. Third, another back operation will only produce another scar and he will not get better.

Mr. Villanueva has reached maximum medical improvement and does not need any further surgery. Mr. Villanueva is capable of light to medium work. He can occasionally lift 40 to 50 pounds and frequently lift 25 pounds. He can drive without restriction and operate machinery.

Dr. Barrash recalled that Dr. Kaldis operated on Mr. Villanueva at L4-L5. Upon his review of the myleogram, he saw scarring at that level. In response to a question on whether scarring was present at L3-L4, Dr. Barrash stated, "Maybe, but not significant." Dr. Barrash also believes Dr. Guerrero's reference to a MRI in an April treatment note is "a mistake" because no mention was made of any back pain complaint then. When asked whether Dr. Guerrero also made a mistake when he requested a lumbar CT scan, Dr. Barrash eventually noted that there was no mention of back

problems at that time either.[14] Dr. Barrash stressed that medical training emphasized the importance of taking a patient's history. He provided an antedote of one medical professor who could render an accurate diagnosis 90% of the time solely based on a patient's history. When queried about whether Mr. Villanueva would have still been experiencing pain from his 1991 back surgery in 1997, Dr. Barrash said it was possible. It was also possible for Mr. Villanueva's postoperative condition to be aggravated. Concerning Mr. Villanueva's functional capacity, Dr. Barrash did not have any faith in the results of tests conducted by chiropractors and the test had been signed by a chiropractic doctor.

After reviewing Dr. Bindel's report in December 2001, Dr. Barrash disagreed with his opinion. According to Dr. Barrash, Dr. Bindel's approach was "overly aggressive" and would only compound Mr. Villanueva's back problems. At present, Mr. Villanueva could return to work in light to medium duties. If he had back surgery, he certainly would not improve beyond light to medium duties and would probably do less. His diabetic neuropathy would not be improved. Finally, according to Dr. Barrash, "That which this gentleman underwent could not have injured 3 disc levels."

Rehabilitation Assessment and Labor Market Surveys
EX 19 and EX 21

In April 2000, Mr. William Quintanilla, a rehabilitation specialist, evaluated Mr. Villanueva's rehabilitation capacity after an interview and a review of his social, educational, employment, and medical histories. First, he concluded that since longshoreman work is characterized as very heavy work, Mr. Villanueva could not return to longshoreman work unless he did so as a foreman of a painting and sandblasting crew that required no more than light duty. According to Dr. Moseley, Mr. Villanueva is capable of medium work with some restrictions or light work without restrictions. He could transfer his skills and become a painter/sandblaster at a medium labor effort level or turn to entry level light duty jobs. On June 8, 2000, several job openings in the Houston area met that criteria including painter/sandblaster ($8 to $13 per hour), forklift operator ($8 per hour), parking lot attendant ($6 per hour), security guard ($6.15 per hour) and driver ($5.50 per hour).

In January 2001, Mr. Quintanilla updated Mr. Villanueva's case and found he was still precluded from returning to work as a longshoreman but could transfer to the related employment as a painter or entered several light duty jobs.

In a January 2002 deposition, Mr. Quintanilla again explained his rehabilitation evaluation process for Mr. Villanueva. At that time, Mr. Villanueva could perform light work and some medium work with a few sitting and standing restrictions. He could be painter supervisor. Some employers don't require their foreman to actually do the work. Likewise, some fork lift operator jobs involve medium effort, others do not. According to Dr. Pennington, Mr. Villanueva could return to his work as a longshoreman. Dr. Brownhill's limitations are restricted medium work and unrestricted light

[14]His initial response was, "I think it was a mistake going to Dr. Guerrero, but that's beside the point."

duty. In terms of transfer of skills, Mr. Villanueva should consider painter foreman or forklift operator. Since his initial review of the local labor market in April 2000, and based on his weekly experience developing labor market surveys, Mr. Quintanilla believes the types of jobs listed in his labor market survey have remained reasonably available in the Houston area since then at about the same pay scale. At the same time, the specific jobs identified in 2000 may no longer be available.

Affidavit of Mr. Wendell Landry
EX 23

According to Mr. Landry, the Employer has continued to pay all reasonable and necessary non-invasive medical treatment for Mr. Villanueva as recommended by DOL in December 2000.

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

### Stipulations of Fact

At the hearing, the parties stipulated to the following facts: a) Mr. Villanueva was involved in a work place accident on April 6, 1997 in the course of, and during, his employment with Port Cooper/T. Smith Stevedoring; b) At the time of the accident, Mr. Villanueva's average weekly wage was $517.51,[15] with a corresponding weekly compensation rate of $345.01; and, c) Port Cooper/T. Smith Stevedoring voluntarily paid compensation to Mr. Villanueva from April 7, 1997 to March 2, 2001[16] (TR, pages 43 to 45).

### Issue No. 1 - Causation

Under the Act, 33 U.S.C. § 902 (2), a compensable "injury" is defined as an accidental injury arising out of and in the course of employment. The courts and Benefits Review Board ("BRB" or "Board") have provided substance and boundaries to this definition through numerous interpretations. First, injury means some physical harm in that something has gone wrong with the human frame. *Crawford v. Director, OWCP*, 932 F. 2d 152 (2d Cir. 1991). Credible complaints of subjective symptoms and pain may be sufficient to establish such physical harm. *Sylvester v. Bethlehem Steel Corp.*, 14 BRBS 234, 236 (1981). Second, a work-related aggravation of a pre-existing condition is an injury under the Act. *Preziosi v. Controlled Indus.*, 22 BRBS 468 (1989). Third, to be a compensable injury under the Act, the employment-related injury need not be the sole cause, or primary factor, in a disability. If an employment-related injury contributes to, combines with, or aggravates a pre-existing or underlying condition, the entire disability is compensable. *Strachen Shipping v. Nash*, 782 (5th Cir. 1986) and *Kooley v. Marine Indus. N. W.*, 22 BRBS 142 (1989). Fourth, even if the claimant's employment aggravates non-work-related, underlying disease or

[15] *See also* CX 20.

[16] *See also* EX 6.

condition so as to produce incapacitating symptoms, the resulting disability is compensable. *Gardner v. Bath Iron Works Corp.*, 11 BRBS 556 (1979) *aff'd sub nom. Gardner v. Director, OWCP*, 640 F.2d 1385 (1st Cir. 1981). Thus, the term "injury" includes aggravation of a pre-existing, non-work-related condition or the combination of work- and non-work-related conditions. *Lopez v. Southern Stevedores*, 23 BRBS 295 (1990).

Injury

With these principles in mind, I first turn to the determination of whether Mr. Villanueva has an injury. During this consideration, no presumption exists.[17] Instead, Mr. Villanueva must prove the existence of some bodily malfunction or harm through the preponderance of the evidence. In that regard, the radiographic evidence and most of the physical examinations corroborate his low back pain complaints. Further, the vast majority of the physicians, who evaluated Mr. Villanueva's low back (Dr. Guerrero, Dr. Lee, Dr. Sanders, Dr. Lazarz, Dr. Brownhill, and Dr. Bindal) found something wrong with his back. Even Dr. Pennington and Dr. Barrash, who question the timing of Mr. Villanueva's pain complaints, the magnitude of his symptoms, and the cause of his back pain complaints, don't really dispute that Mr. Villanueva has something wrong with his back. Accordingly, I find something has gone wrong with Mr. Villanueva's back such that he has an injury within the meaning of the Act.

Accident

Based on parties' stipulation of fact, I find Mr. Villanueva was involved in a work place accident on April 6, 1997.

Section 20 (a) Presumption

If a claimant establishes the existence of an injury, as defined by the Act, and the occurrence of a work-related accident that could have caused the injury, the courts and Benefit Review Board have interpreted Section 20 (a) of the Act, 33 U.S.C. § 920 (a), to invoke a presumption on behalf of a claimant that, absent substantial evidence to the contrary, the injury was caused by the work-related accident. Since Mr. Villanueva has demonstrated the presence of an injury and a work-related accident occurred, I must next determine whether the April 6, 1997 accident could have caused such an injury.

According to Mr. Villanueva (hearing testimony, CX 16, and various medical histories), as corroborated by his supervisor, Mr. Maurice (CX 5), on April 6, 1997, while checking the integrity of lifters on a roll of heavy paper to be loaded on a ship, Mr. Villanueva was forcibly struck in the

[17] *See Devine v. Atlantic Container Lines, G.I.E*, 25 BRBS 15 (1990).

chest by one of the lifters and knocked between the dock and a ship. As he fell, Mr. Villanueva clearly struck his head and the left side of his body, including his left shoulder, elbow, and wrist. Although Mr. Villanueva may not have initially reported that he also struck his back during the fall, the force of the lifter's blow was sufficient to cause a bump on the left side of Mr. Villanueva's head, which later led to treatment by Dr. Kahkeshani (CX 3) and a muscle tear in his left shoulder, which eventually required arthrosporic surgery by Dr. Moseley (CX 4). Based on both the force of the lifter's blow and the other manifested injuries to Mr. Villanueva's body involving his head and shoulder, I find the fall Mr. Villanueva suffered on April 6, 1997 when struck by the crane's lifter could have caused an injury to his back. As a result, Mr. Villanueva has invoked the presumption under the Act that the April 6, 1997 work place accident injured his back.

Substantial Contrary Evidence

To rebut the Section 20 (a) causation presumption, the employer must present specific medical evidence proving the absence of, or severing, the connection between the bodily harm and the employee's working condition. *Parsons Corp. v. Director, OWCP (Gunter)*, 619 F.2d 38 (9th Cir. 1980). The U.S. Circuit courts have rendered different views on the extent of such evidence. In *Brown v. Jacksonville Shipyards, Inc.*, 554 F.2d 1075 (11th Cir. 1990), the U.S. Court of Appeals for the Eleventh Circuit required that the employer produce evidence which ruled out the possibility of a causal relationship between the claimant's employment and injury. On the other hand, in *Conoco, Inc. v. Director, OWCP [Prewitt]*, 194 F.3d 684 (5th Cir. 1999), the U.S. Court of Appeals for the Fifth Circuit rejected the "rule out" standard. Instead, according to that court, an employer must produce evidence that a reasonable mind might accept as adequate to support a conclusion that the accident did not cause the injury.

Since this case arises in the Fifth Circuit, I am guided by the *Conoco* standard and find based on the medical opinions of Dr. Pennington (EX 14) and Dr. Barrash (EX 15, EX 20, and EX 21) that Port Cooper has satisfied the requisite burden of production to rebut the Section 20 (a) presumption in this case. Specifically, after reviewing some of the radiographic evidence and twice examining Mr. Villanueva, Dr. Pennington stated he found no objective evidence that the April 6, 1997 accident had caused any permanent injury to Mr. Villanueva's back. He opined the diagnostic studies showed degenerative changes consistent with Mr. Villanueva's age and his postoperative status. Additionally, suspicious of Mr. Villanueva's subjective complaints, the physician found nothing in his examination to support a conclusion that he suffered an injury. Dr. Barrash essentially reached the same conclusions. Disagreeing with several radiographic interpretations, Dr. Barrash concluded those studies only disclosed postoperative and degenerative changes. Based on his examinations, Dr. Barrash also opined that Mr. Villanueva's symptoms were the residual effects of his prior back surgery or related to diabetes.

Causation Determination

Once the Section 20 (a) presumption is rebutted, it no longer controls the adjudication. *Swinton v. J. Frank Kelly, Inc.* 554 F.2d 1075 (D.C. Cir.) *cert. denied* 429 U.S. 820 (1976). Instead,

I must weigh all the evidence in the record and determine the causation issue based on the preponderance of the evidence. *Noble Drilling Co. v. Drake*, 795 F.2d 478 (5th Cir. 1986).

Preliminary Findings

Due to the nature of Mr. Villanueva's presently claimed injury and the potential relationship to his prior back surgery, some preliminary findings concerning his 1990 accident and subsequent surgery are appropriate.

Based on an undisputed interpretation, the November 20, 1990 MRI of Mr. Villanueva's back disclosed the following: a) along the entire spine, L3 to S1 - marked spinal stenosis congenitally narrowed spinal canal; b) at L3-L4 - disc degeneration, with an anterior herniation; and minimal left postero central focal bulge; and, c) at L-4-L5 - marked compression due to spinal stenosis and a postero central herniation with anterior compression of the thecal sac (CX 26). On February 12, 1991, during Mr. Villanueva's back surgery, Dr. Kaldis identified a protruding disc at L4 and performed a discectomy (excision of an intervertebral disc[18]) (CX 26). He also accomplished a laminectomy (excision of the posterior arch of a vertebra[19]) on L4 and the inferior aspect of L5.

Definitive Findings

Concerning causation, the medical experts in this case disagree in three fundamental areas. The first dispute concerns the actual interpretation of the "objective" radiographic studies of Mr. Villanueva's back. The second disagreement among the physicians concerns the current condition of Mr. Villanueva's back. The third, and central, the doctors have divergent opinions on the cause of Mr. Villanueva's back condition. My determination in each of these areas will establish whether Mr. Villanueva is able to carry his burden of proving a work-related injury to his back.

*Radiographic Interpretations*

In 1997, Dr. Lee, a board certified diagnostic radiologist, interpreted a lumbar CT scan, lumbar myleogram , a post myleogram CT scan, a CT scan with contrast, and an MRI as follows: L3-L4, large 8 mm herniated disc, mostly left, severe left spinal stenosis, diffuse anterior bugled disc; L4-L5, post operative changes, previous laminectomy, 5 mm recurrent herniated disc, significant central spinal stenosis; and, L5-S1, post operative changes, previous laminectomy, 3 mm broad based diffuse recurrent herniated disc. In relevant terms, Dr. Lee found postoperative changes and recurrent herniation at L4-L5 and L5-S1 and an uncorrected herniated disc at L3-L4 (CX 8 and CX 31).

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[18]DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, page 492.

[19]*Id.* at 898.

In 1997, Dr. Mark Sanders, board certified in both orthopaedic and neurological surgery, also reviewed the MRI scan, CAT scans and myleograms (CX 10). He found at L3-L4, an 8 mm herniated disc with a sequestered fragment off to the left and at L4-L5, evidence of a previous laminectomy.

In February 2001, Dr. Linda L. Hankins interpreted MRIs of Mr. Villanueva's lumbar spine, with and without contrast, as follows: at L4-L5, left disc protrusion about 5 to 6 mm, indenting the left ventral thecal sac, with moderate bilateral narrowing; and, at L5-S1, bilateral laminectomies with posterior spondylosis (degenerative joint disease affecting the lumbar vertebrae[20]) and narrowing. Based on Dr. Lazarz's explanation concerning the transitional vertebra (*see below*, and CX 21), Dr. Bindal's similar findings, and noting the absence of any mention by Dr. Hankins of a laminectomy at L4-L5, I interpret her readings to mean a finding of a 5 to 6 mm left disc protrusion in the same area identified by the other physicians as L3-L4 (CX 34).

In 1999, Dr. Donald Lazarz, a board certified orthopaedic surgeon, initially only had the reported results of the 1997 radiographic tests and his own x-ray study of Mr. Villanueva's lumbar spine to consider (CX 21 and CX 22). He noted the reports of the 8 mm rupture at L3 and problems at L4. He interpreted his x-rays to show a fusion mass at L5 to S1 with motion occurring at L4-L5. Based on this evidence, Dr Lazarz expressed a need to know whether Mr. Villanueva had a fusion up to L4. By March 2001, Dr. Lazarz had Dr. Hankins' lumbar MRI to review which showed a lesion at L4. Due to a transitional vertebra, Dr. Lazarz stated this was the same lesion previously identified at L3.

In November 2001, Dr. Bindal, a board certified neurosurgeon, observed in the lumbar MRIs, including Dr. Hankins' February 2001 study, at L3-L4, a herniated disc; and, at L4-L5, a herniated disc and evidence of a previous laminectomy (CX 29).

In December 1999, Dr. Jack Pennington, a board certified orthopaedic surgeon, reviewed the radiographic evidence and concluded the studies showed degenerative and arthritic changes consistent with Mr. Villanueva's age and prior back surgery (EX 14).

In 2001, Dr. Martin Barrash reviewed the radiographic tests and observed only degenerative and post operative scarring (EX 15). Further, in contrast to Dr. Lee's opinion, Dr. Barrash specifically did not see any left lateral defect or a large diffuse herniated disc at L3-L4.

In summary, both radiologists, Dr. Lee and Dr. Hankins, two neurosurgeons, Dr. Sanders and Dr. Bindal, and an orthopaedic surgeon, Dr. Lazarz, observed either a lesion, disc protrusion and/or herniated disc at L3-L4. On the other hand, the other neurosurgeon, Dr. Barrash, and orthopaedic surgeon, Dr. Pennington, do not see such a lesion.

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[20] *Id.* at 1564.

To resolve this medical expert dispute, I first turn to the physicians' respective expertise and note Dr. Barrash's position that he, as a neurosurgeon, is in a better position than a radiologist to interpret the lumbar radiographic tests. That is, Dr. Barrash clearly honors his interpretation over that of Dr. Lee. Recognizing a medical debate may exist between board certified radiologists and neurosurgeons, I do not take a position on who is better qualified to interpret lumbar radiograph films. However, even if Dr. Barrash's view is correct, the other two board certified neurosurgeons in this case, Dr. Sanders and Dr. Bindal, agree with radiologists, Dr. Lee and Dr. Hankins, rather than Dr. Barrash.[21]

Next, in terms of medical reasoning, the opinions of Dr. Lee and Dr. Hankins, have some enhanced probative value because they first presented exceptionally detailed observations and then rendered reasonable conclusions based on their findings. In contrast, Dr. Pennington and Dr. Barrash simply presented their contrary interpretative conclusions that the films showed aging and post operative changes in Mr. Villanueva's back without describing in detail their specific observations or location of the defects. This reasoning shortfall is problematic since I am uncertain, for comparison purposes, which locations on the spine they observed degenerative changes, post operative changes, or both.

Finally, the clear preponderance of the board certified physicians in this case, Dr. Lee, Dr. Sanders, Dr. Lazarz, Dr. Hankins, and Dr. Bindal find a disc protrusion, lesion or herniated disc at L3-L4. Their effective concurrence outweighs the contrary opinions of Dr. Pennington and Dr. Barrash that only post operative or aging defects are present. Further, I find that the concurrent findings by Dr. Lee, Dr. Sanders, and Dr. Bindal establishes that the radiographic evidence in this case shows Mr. Villanueva has a herniated disc at L3-L4.

*Mr. Villanueva's Current Back Condition*

As readily apparent by the previous discussion, several physicians believe Mr. Villanueva has a disc problem at L3-L4. Shortly after the April 1997 accident and into 1998, based on physical examinations (positive leg lifts, low back pain, and tenderness upon palpatitation), multiple treatments, lumbar CT scans and other tests, Dr. Guerrero diagnosed and treated, Mr. Villanueva's low back pain and lumbar radiculopathy, and recommended further treatment (CX 2). Upon referral near the end of 1997, in addition to radiographic evidence of a herniated disc, Dr. Sanders also found positive leg lifts and reduced quadriceps strength on the left side and diagnosed a disabling herniated lumbar disc (CX 10). When Dr. Lazarz evaluated Mr. Villanueva in the fall of 1999, he discovered limited range of motion, muscle spasms, and numbness in the left toe (CX 21 and CX 22). Pending further radiographic tests, Dr. Lazarz deferred a diagnosis. A March 2000 examination disclosed continued low back pain, muscle spasms and lumbar tenderness. Likewise, in January 2001, Dr. Lazarz noted decreased thigh muscle and sensorary deficits in the legs. When the February 2001 MRI

[21]In his deposition, Dr. Barrash also expressed his personal opinion on the medical caliber of the various physicians and the value of a chiropractic functional capacity evaluations. I found little foundation in the record for, or relevance in, his comments.

showed a disc problem at L3, Dr. Lazarz then concluded Mr. Villanueva need corrective surgery in that area. Finally, in November 2001, Dr. Bindal observed Mr. Villanueva's low back pain upon bending and twisting, muscle spasms and tenderness (CX 29). In light of the examination and a review of the MRIs, Dr. Bindal concluded Mr. Villanueva had a herniated disc at L3-L4 and suffered a back injury due to his fall in April 1997.

In contrast, other physicians found little wrong with Mr. Villanueva's back. Although he did not conduct a formal back examination, Dr. Moseley did note the absence of any mobility problem in 1997, which he considered remarkable in light of the MRI showing a herniated disc (DX 4). In November 2000, when Mr. Villanueva's demonstration of flexion limitation and lumbar tenderness were contradicted by straight leg lifts, Dr. Brownhill concluded he was doing well (DX 24). While Mr. Villanueva had back pain and was thus limited in terms of capacity for work, Dr. Brownhill found no evidence of radiculopathy. Likewise, Dr. Pennington's 1999 and 2000 physical examinations failed to verify Mr. Villanueva's pain complaints (EX 14).[22] His leg lifts were negative and no neurological defects were observed. Additionally, Mr. Villanueva had no mobility problems. As a result, Dr. Pennington opined Mr. Villanueva only had degenerative and arthritic changes to his low back and was capable of returning to his longshore work. Finally, in his multiple examinations of Mr. Villanueva's back from 1997 to 2001, Dr. Barrash found neither muscle spasms nor atrophy. The only physical finding was diminished sensation in the left leg, which he ultimately attributed to diabetes. Based on the examination and the absence of any herniated disc or acute problem within the lumbar MRIs and CT scans, Dr. Barrash concluded Mr. Villanueva did not have a herniated disc or any significant condition at L3-L4. Instead, his back problem was due to post operative and degenerate changes.

To resolve this dispute in medical opinion, my first task is to assess relative probative weight of the diverse medical opinions. The two factors I consider in evaluating relative probative weight are: a) documentation and b) reasoning.

As to the first factor, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor of reasoning involves an evaluation of the connections a physician makes

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[22]At one point, Dr. Pennington suggested Mr. Villanueva may be magnifying his symptoms. However, no tests for malingering were conducted and none of the other physicians to personally examine his lower back pain questioned the validity of his complaints. Further, as I have previously determined, radiographic evidence does reveal the existence of a disc dysfunction at L3-L4. As a result, I conclude his subjective pain complaints were valid.

based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight . *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

With that criteria in mind, I first observe that Dr. Brownhill's conclusion that Mr. Villanueva's back pain was probably due to a degenerative disc also has diminished relative probative value because it is not well documented. Notably, Dr. Brownhill rendered his opinion without the benefits of the multiple x-rays, MRIs' and CT scans of Mr. Villanueva's lumbar spine. In the same manner, as he acknowledged, Dr. Moseley did not conduct a formal evaluation of Mr. Villanueva's low back, and focused on Mr. Villanueva's left shoulder injury. As a result, his implication that Mr. Villanueva's clinical symptoms seemed inconsistent with a herniated disc is less documented than other medical opinions in the record and has correspondingly lessened probative value. Not surprisingly, in terms of documentation, the opinions of Dr. Pennington and Dr. Barrash have diminished probative value because they rely in part on their interpretations of the radiographic evidence which is contrary to my finding. Additionally, Dr. Pennington didn't consider the functional capacity study showing Mr. Villanueva, at best, can achieve only medium work level which is inconsistent with Dr. Pennington's recommendation that Mr. Villanueva may return to his longshoreman work requirung very heavy labor.

In comparison, the evaluations of Dr. Guerrero, Dr. Sanders, Dr. Lazarz, and Dr. Bindal are better documented because they based their opinions on examinations coupled with radiographic interpretations which are consistent with my finding. Accordingly, I give their opinions more probative weight and find their consensus opinion that Mr. Villanueva has significant disc damage at L3-L4 outweighs the less probative opinions of Dr. Brownhill, Dr. Pennington, and Dr. Barrash, and the observation of Dr. Moseley.

Further, based on their extensive review of the entire record, I find the opinions of Dr. Lazarz and Dr. Bindal the best reasoned assessments of Mr. Villanueva's back condition and most consistent with all the objective medical evidence, in particular, the radiographic findings of a herniated disc. Based on their most probative evaluations, as additionally supported by the well reasoned opinions of Dr. Guerrero and Dr. Sanders, I find Mr. Villanueva has a herniated disc at L3-L4 which causes low back pain upon twisting and bending, muscle spasms, and some loss of sensation in his legs.

*Cause*

Since they opined that Mr. Villanueva only had degenerative and post operative back problems, and did not have a compensable injury, Dr. Pennington and Dr. Barrash essentially believed his fall on April 6, 1997 did not cause his low back problems. However, I have already determined their opinions have diminished probative due to documentation shortfalls. On this particular issue, their opinions are even less helpful. Because they do not think Mr. Villanueva has a herniated disc, they are hardly in a position to determine whether his fall at work caused that injury.

Of the doctors who did find a disc problem at L3-L4, Dr. Brownhill and Dr. Bindal expressed a definite opinions on causation. Although he indicated that Mr. Villanueva appeared to be doing well in regard to his back condition, Dr. Brownhill still found his back problem was related to the April 6, 1997 accident. Again, for documentation reasons, Dr. Brownhill's opinion has some probative value shortfalls. However, Dr. Bindal's assessment does not have any similar probative deficiencies. Instead, his well documented and reasoned medical opinion definitively supports a finding that Mr. Villanueva significantly damaged his disc at L3-L4 when he was knocked down on April 6, 1997.

In addition to Dr. Bindal's probative finding, I have also considered other factors in determining the causation issue. First, to refute the proposition that Mr. Villanueva's back condition is merely a continuation of degenerative changes or the effects of his 1990 back operation, Mr. Villanueva has credibly and rationally emphasized that prior to his April 1997 accident his back did not preclude his work as a longshoreman. His testimony is corroborated both by the parties' stipulation that he was earning over $500 a week at the time he was injured and undisputed evidence that he made nearly $27,000 working as a longshoreman the 12 months just prior to his accident (CX 20). In contrast, as will be discussed subsequently in more detail, the record clearly establishes that after his April 1997 accident, due to his back condition, Mr. Villanueva can no longer return to his work as longshoreman.

Second, and relatedly, as reported by Dr. Kaldis, at the end of 1990, Mr. Villanueva's back at L3-L4 showed an unspecified herniation and minimal bulge, which did not require any surgical correction. Yet, in comparison, the MRIs and CT scans taken within a few months of the April 1997 accident showed a 5 to 8 mm herniated disc in the same location. Since Mr. Villanueva worked as a longshoreman prior to his accident without apparent impairment, the change at L3-L4 was identified in relative close proximity to the accident, and his post-accident back symptoms both correspond to the disc damage and impair his work capacity, circumstantial evidence also exists to link the herniated disc to the accident.

Third, I have considered that the absence of documentation about low back pain immediately following the April 1997 accident. However, I found Mr. Villanueva to be a credible witness. Absent a sufficient basis to impeach his testimony and considering that his head and left side unquestionably received blunt trauma during his fall, I accept his explanation that the initial treatment focus was on his head and left shoulder. Additionally, within eight days of the accident, Dr. Guerrero did request a lumbar study. Although Dr. Barrash speculated Dr. Guerrero must have been mistaken to have made such a request in the absence of previously documented low back complaint, I note that Dr. Guerrero's action can also be viewed as consistent with Mr. Villanueva's testimony that the first focus during his treatment was on his head and shoulder. In balancing Dr. Barrash's speculation with Mr. Villanueva sworn testimony before me, I find Mr. Villanueva sufficiently credible to determine that the absence of low pain back documentation just after the accident does not preclude a finding of causation.

Based on my review of the entire record, I find the preponderance of the more probative

evidence establishes that Mr. Villanueva injured his back in his work-related accident on April 6, 1997 to the extent that he suffered a herniated disc at L3-L4. Accordingly, Mr. Villanueva has proved that he suffered a compensable injury to his back on April 6, 1997.

**Issue No. 2 - Medical Treatment, Maximum Medical Improvement, and Nature of Disability**

Under Section 7 (a) of the Act, 33 U.S.C. § 907 (a), an employer shall furnish all reasonable and necessary medical care and other attendant care or treatment, hospitalization, and medication for a work-related injury. *Pernell v. Capitol Hill Masonry*,11 BRBS 532, 539 (1979). The term "necessary" relates to whether the medical care is appropriate for the injury.[23] *See* 20 C.F.R. § 702.402. Consequently, an administrative law judge may reject payment for unnecessary treatment. *Ballesteros v. Williamette W. Corp.*, 20 BRBS 184, 197 (1988).

The claimant bears the burden to establish that the claimed medical expenses are related to a work-related injury. *Pardee v. Army & Air Force Exch. Serv.*, 13 BRBS 1130, 1138 (1981). A claimant may establish a *prima facie* case of compensable medical treatment where a qualified physician indicates such treatment is necessary for a work-related injury. *Turner v. Chesapeake & Potomac Tel. Co.*, 16 BRBS 255, 257 (1984). In light of this burden of proof, a preliminary finding of a work-related injury is required. *Id*.

A claim for medical benefits is never time-barred. *Colburn v. General Dynamics Corp*., 21 BRBS 219, 222 (1988). In fact, the employer has a continuing obligation to pay an injured employee's medical expenses even if the claim for disability compensation is time-barred by Section 12 (time limits for filing notice of an injury or occupational disease) or Section 13 (time limits for filing a compensation claim) of the Act. *Strachan Shipping Co. v. Hollis*, 460 F.2d 1108 (5th Cir.), *cert. denied* 409 U.S. 887 (1972). In addition, Section 7 does not require that the injury be economically disabling; instead, the injury need only be work-related. *Ballesteros*, 20 BRBS at 187.

Although the consequences of a work related injury may require long term medical treatment, an injured employee reaches maximum medical improvement ("MMI") when his condition has stabilized. *Cherry v. Newport News Shipbuilding & Dry Dock Co.*, 8 BRBS 857 (1978). In other words, the nature of the worker's injured condition becomes permanent and the worker has reached maximum medical improvement when the individual has received the maximum benefit of medical treatment such that his condition will not improve. *Trask v. Lockheed Shipbuilding & Constr. Co.*, 17 BRBS 56, 60 (1985).

Any disability suffered by a claimant prior to MMI is considered temporary in nature. *Berkstresser v. Washington Metropolitan Area Transit Authority*, 16 BRBS 231 (1984). If a claimant has any residual disability after reaching MMI, then the nature of the disability is permanent.

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[23]The term "reasonable" addresses the actual cost of treatment and has not been raised as an issue before me. *See Pernell*, 11 BRBS at 539.

*Sinclair v. United Food & Commercial Workers*, 13 BRBS 148 (1979). Consequently, the determination of MMI is based on medical evidence, regardless of economic or vocational considerations. *Ballesteros v. Williamette Western Corp.*, 20 BRBS 184, 186 (1988). Usually, in the absence of contrary evidence, an injured worker has not reached maximum medical improvement when additional surgery is anticipated. *Kuhn v. Associated Press*, 16 BRBS 46, 48 (1983). Further, after surgery, a worker has reached maximum medical improvement only after the duration of the prescribed recovery. *Walker v. National Steel & Shipbuilding Co.*, 8 BRBS 525, 528 (1978).

With these principles in mind, and based on my prior findings, Mr. Villanueva has already proved the existence of a work-related injury to his low back. As a result, since the Employer has indicated that it continues to provide non-invasive medical treatment for Mr. Villanueva, the sole issue concerning medical treatment is whether back surgery is an appropriate, or necessary, treatment for his injury.

In terms of the necessity of back surgery, a familiar line divides the medical experts. Dr. Guerrero, Dr. Sanders, Dr. Lazarz, and Dr. Bindal recommend back surgery for repair of Mr. Villanueva's disc problem at L3-L4.[24] On the other hand, based on their opinions that Mr. Villanueva did not have a significant back problem, Dr. Brownhill, Dr. Pennington, and Dr. Barrash considered Mr. Villanueva to be at maximum medical improvement without any need for back surgery. As before, since I have now determined that Mr. Villanueva does have a substantial back injury, the conclusion of Dr. Brownhill, Dr. Pennington, and Dr. Barrash have little probative value on his need for back surgery. Accordingly, based on the more probative opinions of Dr. Guerrero, Dr. Sanders, Dr Lazarz and Dr. Bindal, I conclude that back surgery for repair of Mr. Villanueva's damaged disc at L3-L4 is a necessary medical treatment. Correspondingly, again based on the recommendations of Dr. Guerrero, Dr. Sanders, and Dr. Bindal that Mr. Villanueva will benefit from such surgery, I find that he has not reached maximum medical improvement and that the nature of any impairment associated with the back injury is temporary.

**Issue No. 3 - Extent of Disability**

Under the Act, a longshoreman's inability to work due to a work-related injury is addressed in terms of the extent of the disability (total or partial) and the nature of the disability (permanent or temporary). In a claim for disability compensation, the claimant has the burden of proving, through the preponderance of the evidence, both the nature and extent of disability. *Trask*, 17 BRBS at 59. As I have already concluded, the nature of Mr. Villanueva's back injury is temporary at this time.

The question of the extent of a disability, total or partial, is an economic as well as a medical concept. *Rinaldi v. General Dynamics Corp.*, 25 BRBS 128, 131 (1991). The Act defines disability as an incapacity, due to an injury, to earn wages which the employee was receiving at the time of

[24]Dr. Lee, Dr. Hankins, Dr. Moseley, and Dr. Kahkeshani did not express an opinion concerning the need for back surgery. Dr. Moseley did find Mr. Villanueva at maximum medical improvement on October 9, 1999. However, his determination was limited to the condition of Mr. Villanueva's left shoulder after shoulder surgery.

injury in the same or other employment. *McBride v. Eastman Kodak Co.*, 844 F.2d 797 (D.C. Cir. 1988). Total disability occurs if a claimant is not able to adequately return to his or her pre-injury, regular, full-time employment. *Del Vacchio v. Sun Shipbuilding & Dry Dock Co.*, 16 BRBS 190, 194 (1984). A disability compensation award requires a causal connection between the claimant's physical injury and his or her inability to obtain work. The claimant must show an economic loss coupled with a physical and/or psychological impairment. *Sproull v. Stevedoring Servs. of America*, 25 BRBS 100, 110 (1991). Under this standard, a claimant may be found to have either suffered no loss, a partial loss, or a total loss of wage-earning capacity.

Determining the extent of Mr. Villanueva's disability after his April 1997 injury, and consequently whether an award of disability benefits is appropriate, involves a three step process. *SEACO and Signal Mutual Indemnity Assoc., Limited v. Bess*, 120 F.3d 262 (4th Cir. 1997) (unpublished); *see also Newport News Shipbuilding & Dry Dock Company v. Tann*, 841 F.2d 540, 542 (4th Cir. 1988). As a first step, to establish a *prima facie* case of total disability, whether temporary or permanent in nature, a claimant has the initial burden of proof to show that he or she cannot return to his or her regular or usual employment due to work-related injuries. This evaluation of loss of wage earning capacity focuses both on the work that an injured employee is still able to perform and the availability of that type of work which he or she can do. *McBride*, 844 F.2d at 798. At this initial stage, the claimant need not establish that he cannot return to any employment, only that he cannot return to his former employment. *Elliot v. C & P Tel. Co.*, 16 BRBS 89 (1984). A claimant's credible testimony of considerable pain while performing work may be a sufficient basis for a disability compensation even though other evidence indicates the claimant has the capacity to do certain types of work. *Mijangos v. Avondale Shipping, Inc.*, 948 F. 2d 194 (8th Cir. 1999); *Anderson v. Todd Shipyards Corp.*, 22 BRBS 20 (1989).

*Prima Facie* Case

Prior to his injury, Mr. Villanueva was employed as a longshoreman in an unrestricted work capacity. Due to his low union classification, he usually obtained work inside the hull of ships moving heavy cargo and steel. Based on his description of his pre-injury employment and the opinions of two rehabilitation specialists to consider his case (Mr. Stanfill (CX27) and Mr. Quintanilla (EX 19)), I conclude that Mr. Villanueva's former work as a longshoreman required very heavy labor.

Since his injury, Mr. Villanueva has not returned to the docks, and with the sole exception of Dr. Pennington, all the other physicians to consider his ability to return to such work (Dr. Guerrero, Dr. Sanders, Dr. Brownhill, and Dr. Barrash)[25] concurred in the finding Mr. Villanueva incapable of returning to his former heavy labor longshoreman work. Based on this preponderance of medical opinion, I conclude Mr. Villanueva has proved that he can not return to his former work as a longshoreman. Thus, he has established a *prima facie* case of total disability.

Suitable Alternative Employment

[25]Post-surgery and recovery, Dr. Moseley imposed no work limitations due to Mr. Villanueva's left shoulder. However, he did not address any limitations due to Mr. Villanueva's back condition.

If a claimant is able to demonstrate he is unable to return to his former job, then in the second step of the disability adjudication process, the employer has the burden of production to show that suitable alternate employment is available. *Nguyen v. Ebbtide Fabricators*, 19 BRBS 142 (1986). The availability of suitable alternative employment involves defining the type of jobs the injured worker is reasonably capable of performing, considering his or her age, education, work experience and physical restrictions, and determining whether such jobs are reasonably available in the local community. *Newport News Shipbuilding and Dry Dock Co. v. Director*, OWCP, 592 F.2d 762, 765 (4th Cir. 1978) and New *Orleans (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031, 1038 (5th Cir. 1981). The showing of available suitable alternative employment may not be applied retroactively to the date of maximum medical improvement. An injured worker's total disability becomes partial on the earliest date that the employer shows suitable alternative employment. *Rinaldi v. General Dynamics Corp.*, 25 BRBS 128, 131 (1991).

As an initial step in considering suitable alternative employment, I must establish Mr. Villanueva's present ability to work. In terms of his present capacity for work, Dr. Brownhill and Dr. Barrash believed Mr. Villanueva could engage in medium work with some restrictions or light duty without any limitations. Yet, since they didn't find Mr. Villanueva had a back injury or needed back surgery, their opinions on his present work capacity has diminished probative value. Dr. Guerrero found Mr. Villanueva completely unable to work. However, I believe his opinion is outweighed by Dr. Sanders, who as a board certified neurosurgeon, is a better qualified physician. After diagnosing a back injury and recommending disc surgery, Dr. Sanders also opined that Mr. Villanueva may not lift anything greater than 20 pounds or climb, bend, kneel, or twist. Additionally, Mr. Villanueva is not capable of working a full eight hour day (CX 10).

Dr. Sanders' limitations are further validated by Mr. Villanueva's failed attempts at employment since his accident. For reasons associated with his back limitations, Mr. Villanueva was unable to hold jobs as a dishwasher (slippery floors), tile setter helper (heavy tile bundles), janitor (stooping requirement), and painter/sandblaster (fatigue and inability to hold pressure hose). A November 2000 functional evaluation test did demonstrate Mr. Villanueva's capacity for some medium work with restrictions and unrestricted light duty. At the same time, I note that while the test showed his ability to perform these tasks, the study also reported his persistent low back pain during this process. As a result, since as a physician Dr. Sanders was in a better position to factor in Mr. Villanueva's pain complaints, I consider his assessment the most probative measure of Mr. Villanueva's ability to return to work.

To establish the existence of suitable alternative employment, Port Cooper has presented the labor market survey developed by Mr. Quintanilla (EX 19 and EX 21). In light of Mr. Villanueva's work limitation as established by Dr. Brownhill of light duty without restrictions or medium duty with range of motion restrictions, and considering Mr. Villanueva's prior work history and education, Mr. Quintanilla first believed that he might be able to return to the docks as a painter/sandblaster or even as a painting/sandblasting foreman which only involved light labor since not all employers required the foreman to engage in the crew's work Additionally, he presented several types of other job opportunities including assembler, forklift operator, parking lot attendant, and driver that were suitable for Mr. Villanueva. According to Mr. Quintanilla, these type of jobs had been available in

April 2000 and generally remained available.

In general terms, Mr. Quintanilla's recommendation loses probative value because he based his job search on the determinations of Dr. Barrash and Dr. Brownhill rather than Dr. Sanders' limitations which are more restrictive in terms of motion restrictions, even with light work, and duration of daily employment. In addition, while some of the job titles, such as parking lot attendant, seem possibly viable, Mr. Quintanilla's recommendation lacks sufficient specificity to determine if they also fit Dr. Sanders' parameters. In particular, a definitive job description in terms of range of motion requirements, is not provided and no information is given as to whether the employer will offer part-time employment. Finally, some of Mr. Quintanilla's job recommendations are adequately refuted by the other rehabilitation specialist, Mr. Stanfill (CX 27 and CX 28). Pointing out that a painting/sandblasting foreman is typically part of a working crew and expected to engage in their activities, including climbing, Mr. Stanfill believed that job was not suitable for Mr. Villanueva. That proposition was validated by Mr. Villanueva who also testified that in his experience, the painting/sandblasting foreman did do some of the work. Mr. Stanfill also believed the forklift operator job was semi-skilled labor and Mr. Villanueva did not qualify.

In summary, for the reasons noted above, and considering Mr. Villanueva's present limited physical capabilities, I find Port Cooper has not produced sufficient evidence of suitable alternative employment to rebut Mr. Villanueva's *prima facie* case of total disability. Consequently, the extent of Mr. Villanueva's disability is total.[26] In light of his compensable injury, the nature of his disability, and the resulting economic impairment, Mr. Villanueva is entitled to compensation for temporary total disability.

**Issue No. 4 - Attorney Fees**

At the hearing, based on the U.S. Court of Appeals for the Fifth Circuit's interpretation of Section 28 of the Act,33. U.S.C. § 928 (which permits the recoupment of a claimant's attorney's fees and costs in the event of a "successful prosecution") in *Staftex Staffing v. Director, OWCP*, 237 F.3d 404 (5th Cir. 2000)[27] *modified on rehearing*, 237 F.3d 409 (5th Cir. 2000), Port Cooper asserts that it should not be held responsible for that portion of an attorney fee associated with extent of disability issue.

As a preliminary matter, I note the *Staftex* case developed in two steps. In its initial decision, 237 F.3d 404 (5th Cir. July 18, 2000), the court reversed the award of an attorney fee for successful prosecution of an average weekly wage dispute. In that case, while the parties had submitted certain issues to the District Director for an informal conference, they never submitted the average weekly

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[26]Since the Employer did not rebut the *prima facie* case of totally disability through a showing of suitable alternative employment, I need not address the third step in this adjudication process which involves the determination of whether Mr. Villanueva is able to prove such suitable alternative employment was not actually available. *See Williams v. Halter Marine Service*, 19 BRBS 248 (1987).

[27]The citation provided by Mr. Williams in his February 2002 closing brief.

wage dispute to such a conference. As a result, no written recommendation concerning the average weekly wage dispute existed. The court held the "plain wording" of Section 28 (b) required: a) an informal conference on the disputed issue; b) a written recommendation on the issue; and c) an employer's refusal to accept the recommendation. *Id*. at 408. Since on the none of those three factors existed, an attorney fee award was not authorized under Section 28 (b).[28]

Upon a request for rehearing, in 237 F.3d 409 (5th Cir. November 1, 2000), the court reversed the result of its decision without effectively altering its position that Section 28 (b) required three elements for an entitlement to an attorney fee. Upon reconsideration of the facts, the court noted that because at the time of the informal conference the employer was paying the rate of compensation requested by the claimant, the claimant had no cause to raise the average weekly wage issue at that meeting. Following the informal conference on the nature and extent of disability, the District Director presented a written recommendation concerning the nature and extent of disability which included a provision for continuing benefits at the compensation rate based on the claimant's version of the average weekly wage. Due to its continued disagreement on the nature and extent issues, the employer did not accept the recommendation. Consequently, the claimant had to obtain an attorney to obtain a resolution of the compensation payments. At the hearing with the administrative law judge ("ALJ"), the employer raised a new issue about average weekly wage asserting the actual average weekly wage was lower than the figure being used for the voluntary compensation rate. Based on these reconsidered facts, the court determined the three requisite elements were satisfied and thus an award of an attorney fee concerning the average weekly wage was appropriate. *Id.* at 410-411.

In my attempt to determine the impact of *Staftex*, as modified, I confess sufficient confusion to warrant deferral of a decision until further submissions by the parties. On the one hand, the U.S. Court of Appeal for the Fifth Circuit has set out three factors that must exist for an attorney fee award under Section 28 (b) and has subsequently interpreted *Staftex*, in *Pool Co. v. Cooper*, 274 F.3 173, 186 (5th Cir. 2001), as clearly establishing an <u>absolute</u> bar to an award of an attorney fee under Section 28 (b) if no informal conference <u>ever</u> took place.[29]

Yet, in the scenario presented by the court in its modification of its initial *Staftex* decision, the court seems to relax its rigid reading of Section 28 (b) if an informal conference did occur on some issue. I reach that conclusion by observing that although the *Staftex* court did not remove its stated requirement that the issue related to the subsequent attorney fee must have been presented at an

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[28]Since the employer in the case had started voluntary compensation within thirty days of the notice of the claimant's injury, and at the time of the informal conference was paying the claimant's requested rate of compensation, an award under Section 28 (a) also was not authorized.

[29]The court did permit an award of an attorney fee under Section 28 (a). Although the employer had initially paid voluntary disability benefits when the claimant stopped working in 1992, it stopped the payments in April 1994. When the claimant filed a compensation claim in March 1995, the employer denied further disability compensation. According to the court, since the employer failed to initiate voluntary payments within 30 days of the March 1995 claim, it was liable under Section 28 (a) for attorney fees. *Pool*, 274 F.3d at 186-187.

informal conference, the average weekly wage issue for which the *Staftex* court eventually permitted an attorney fee clearly was not presented at the parties' only informal conference!

The court seems to excuse that deficiency for three reasons. First, at the time of the informal conference in *Staftex*, the employer was paying compensation at the rate requested by the claimant so there was no need for the claimant to raise the issue then. Second, stated within the informal conference recommendation was a phrase concerning continued compensation. And, third, the employer declined to accept the recommendation.

In Mr. Villanueva's case, while the informal conference recommendation only addressed medical treatment, the two other reasoning factors just noted above arguably exist. First, at the time of the parties' informal conference in June 2000 (EX 8), since the employer was paying voluntary disability compensation,[30] the only dispute on the table was medical treatment. As in *Staftex*, due to the continuing voluntary payments, Mr. Villanueva had no reason to raise an issue concerning the nature and extent of his impairment.

In regards to the other rationale, Port Cooper may not have fully complied with the informal conference recommendation. Following the informal conference, the District Director's representative issued a recommendation in December 2000 (also during the period of on-going voluntary payments by the Employer) containing two parts (EX 10). In the first portion, apparently based on Dr. Brownhill's causation finding and the November 2000 Functional Capacity Evaluation, the claims examiner determined Mr. Villanueva was "entitled to reasonable and necessary medical treatment and diagnostic testing of the lumbar spine as related to the original 4-6-97 injury. . ." Next, the examiner added the current noninvasive medical treatment provided by the treating physician should continue.

The Employer represents that by continuing to provide the recommended noninvasive prescribed treatment, and implicitedly since Dr. Brownhill found no need for back surgery, it fully complied with the recommendation of the informal conference. However, other physicians have included back surgery as necessary treatment. Additionally, Dr. Brownhill believed Mr. Villanueva could return to only medium labor, which implies the potential for a continuing loss of wage earning potential, and corresponding disability compensation. Thus, arguably, the Employer's unilateral termination of any amount of voluntary compensation payment does not reflect full compliance with the informal conference recommendation. Finally, the facts in this case differ significantly from the *Staftex* case in that Port Cooper did not continue its voluntary payments up to the ALJ hearing.

In light of the above comments and principally to permit the parties to more fully digest the implications of *Staftex* on the attorney fees in this case, I will defer a decision on this last issue until the submission of an application for attorney fees and the Employer's response. Accordingly, since I have determined issues in favor of Mr. Villanueva, his counsel, Mr. Arthur, may submit a petition

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[30]Based on the parties' stipulation and EX 6, the Employer voluntarily paid compensation from April 7, 1997 to March 2, 2001.

to recoup fees and costs associated with his professional work before the Office of Administrative Law Judges. Mr. Arthur has thirty days from receipt of this decision and order to file an application for attorney fees and costs as specified in 20 C.F.R. § 702.132 (a). The Employer's attorney, Mr. Williams, has fifteen days from receipt of a fee application to file an objection to the request. Both counsel should: a) address the applicability of the present *Staftex* decision on the attorney fee application in light of the procedural history of this case; and, b) to the extent possible, apportion the amount of attorney fees and costs between the medical treatment issue and the extent of disability determination.

## ORDER

Based on my findings of fact, conclusions of law, and the entire record, I issue the following order. The specific dollar computations of the compensation award shall be administratively performed by the District Director.

1. The Employer, PORT COOPER/T. SMITH STEVEDORING, **SHALL FURNISH** the Claimant, MR. EDMUNDO R. VILLANUEVA, **MEDICAL TREATMENT**, including back surgery at L3-L4, as required by the back injury caused by the April 6, 1997 accident, in accordance with Section 7 (a) of the Act, 33 U.S.C. § 907 (a).

2. The Employer, PORT COOPER/T. SMITH STEVEDORING, **SHALL PAY** the Claimant, MR. EDMUNDO R. VILLANUEVA, compensation for **TEMPORARY TOTAL DISABILITY** due to the back injury caused by the April 6, 1997 accident, based on Mr. Villanueva's pre-injury average weekly wage of $517.71, and continuing, such compensation to be computed in accordance with Section 8 (b) of the Act, 33 U.S.C. § 908 (b).

3. The Employer, PORT COOPER/T. SMITH STEVEDORING, shall receive credit for all amounts of compensation previously paid to the Claimant, MR. EDMUNDO R. VILLANUEVA as a result of his back injury from the April 6, 1997 accident.

**SO ORDERED:**

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: December 20, 2002
Washington, D.C.

Attachment No. 1

American Board of Medical Specialties«

Certification:

Linda Lee Hankins, MD
Houston, Texas

Certified by: The American Board of Radiology

General Certificate: Diagnostic Radiology

Subspecialty Certificate: Neuroradiolgy

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