

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 24 April 2012

Case No: 2011-LHC-00079
OWCP No: 05-131383

In the Matter of:

ALLAN V. PARKMAN,
Claimant,

v.

MARINE REPAIR SERVICE/
SIGNAL MUTUAL INDEMNITY ASSN., LTD.,
Employer/Carrier,

And

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Parties-in-Interest.

APPEARANCES: Gregory Camden
Attorney for Claimant

John Barrett
Attorney for Employer

BEFORE: KENNETH A. KRANTZ
Administrative Law Judge

DECISION AND ORDER- AWARDING BENEFITS

This proceeding arose upon the filing of a claim for disability benefits under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. §§ 901-950 (2010) ("Act" or "LHWCA"). A formal hearing was held on March 8, 2011, in Newport News, Virginia. Claimant submitted Exhibits 1 through 12, Employer submitted Exhibits 1 through 9,

the parties jointly submitted one Exhibit, and the Administrative Law Judge submitted Exhibits 1 through 5.¹ All exhibits were received into evidence without objection. (TR 4-7)

Both parties filed post-hearing briefs. The findings and conclusions which follow are based on a complete review of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations, and pertinent precedent.

STIPULATIONS (JX 1)

The parties have stipulated and I concur with the following:

1. The LHWCA, 33 U.S.C. § 901 et seq., as amended, applies to this claim;
2. An employer/employee relationship existed between the parties at all relevant times;
3. Claimant alleges an injury to his lower back and right leg having occurred on June 21, 2010;
4. Timely notice of injury was given by Claimant to Employer;
5. Timely claim for compensation was filed by Claimant;
6. Employer filed a timely First Report of Injury with the Department of Labor and a timely Notice of Controversion;
7. Claimant's average weekly wage ("AWW") at the time of injury was \$959.79 resulting in a compensation rate of \$639.86.
8. Claimant has not been paid any benefits as a result of the injury.

ISSUES (TR 3-4)

1. Determine whether Claimant's lower back and right leg injuries arose out of and in the course of employment, and, as such, are compensable injuries under the Act.
2. Determine whether Claimant is entitled to temporary total disability (TTD) payments from June 21, 2010 through January 5, 2011.

¹ The following abbreviations will be used as citations to the record:

CX – Claimant's Exhibit
EX – Employer's Exhibit
JX – Joint Exhibit
AX – Administrative Law Judge's Exhibit
TR – Transcript of March 8, 2011 hearing

3. Determine whether Claimant is entitled to medical expenses to the degree allowable under Section 7 of the Act.

BACKGROUND

Claimant had worked for Employer for approximately five years at the time of the alleged injury. Prior to June 21, 2010, Claimant was receiving ongoing medical treatment for his back under Drs. Partington and Hansen. He alleges suffering an aggravation on June 21, 2010, while working for Employer. He subsequently came under the care of Dr. Wardell. He was released to full time work on January 6, 2011 and at the time of hearing continued to treat with Dr. Wardell. Employer asserts that the injury was not aggravated by his employment and, alternately, that if he was injured it was minor and should have resolved to baseline within 90 days. (TR 7-9)

SUMMARY OF EVIDENCE

Claimant's Testimony (TR 9-24)

Prior to joining the International Longshoreman's Association (ILA) Claimant worked 14 years for Newport News Shipyard as a welder. He testified that welding work is not as heavy as the work he does now. He was involved in two motorcycle accidents in 2005.

Claimant testified that he is now a member of the ILA, Local 1970, performing container repairs on the waterfront. He has worked in this capacity for Employer for five years at 40 hours per week.

Claimant repairs containers that are damaged while being unloaded from the ship. He works on any part of the container that is damaged, including the subfloor, floor, ceiling, roof, sides, front, and back. He cuts out material, fabricates and installs new material, welds, paints, and ships the container back out of the shop.

He testified that the heaviest item he lifts is a 20-ton jack measuring 8 feet in length and weighing around 175 pounds. He uses tools, including hammers, pry bars, air tools, and whatever is needed to fabricate, bend, and shape steel.

Claimant testified that he had back problems prior to June 21, 2010. On that date he was treating with Dr. Partington and Dr. Hansen. The pain has not been constant for the past five years but it aggravates him from time to time.

His wife, a nursing student, originally referred him to Dr. Partington, a neurosurgeon, in July 2008. He saw Dr. Partington off and on for two years, sometimes being taken off work to let the back heal itself. The doctor took him off work from July to September 2008, and again briefly in May 2009. Claimant testified that these were the only times he was off work due to back pain. He did not take other days off from time to time due to back pain. Claimant understood that there was not much Dr. Partington could do for him other than help manage the

pain. He did not see Dr. Partington between May 18, 2009 and June 10, 2010. Dr. Partington had scheduled a bone scan for June 23, 2010. The purpose of the bone scan was to pinpoint the area where he had received cortisone shots in the past.

Dr. Hansen was his pain management specialist. Claimant does not like taking medication and wanted to see a pain management physician to help control his pain. On June 21, 2010, he was taking Percocet or some kind of pain medicine prescribed by Dr. Hansen.

On June 21, 2010, Claimant was inserting a corner post on a damaged refrigeration unit. The repair required him to bend out a two-foot long flange made of heavy, hard, quarter-inch thick steel. The only means of accomplishing this objective was through use of a four-foot long pry bar. The length of the pry bar was necessary to get the proper leverage to bend the tough material of the flange. Claimant had to pry the flange off in sections until it was straight.

The pry bar slipped off the flange a couple of times during this task. Due to the amount of pressure and effort required to bend the flange, each time the pry bar slipped, it caused Claimant's body to jolt. He borrowed his coworker's pry bar, which was a little more effective but still slipped off the flange multiple times. Claimant explained that there was very little space in between the flange and the plate behind it, so he could not slide the pry bar very far in. After 60 to 90 minutes, he finished straightening the two-foot section of flange. He completed this task around 4:00 p.m. and was scheduled to leave at 5:00 p.m. so he completed his shift that day.

Claimant reported that he didn't feel anything until he was in his car that afternoon. Sometimes his back hurt when he was doing his job, so initially he did not think it was a big deal. He felt a sharp, stabbing pain but it was "light and mild." It continued to worsen that night and he was still in "quite a bit" of pain the next morning, but he "thought it might work itself out." (TR 14) He thought he might have pulled a muscle.

Claimant testified that on the next morning, June 22, when he reported for work, his supervisor, Lester Cribbs, immediately asked him what was wrong with him. He told Mr. Cribbs that he had pulled his back the day before when he was prying the corner post. He did not say he wanted to file a workers' comp claim and Mr. Cribbs did not send him for a drug test or to a doctor. Mr. Cribbs said that Claimant could take the day off if he did not feel like he could make it through. Claimant started work at 8:00 a.m. and realized by 8:30 a.m. that "there was no way [he could] work that day." *Id.* He notified Mr. Cribbs and left at 9:00 a.m. to go home.

On June 23 he underwent the scheduled bone scan. On that date he knew his back was different and he was still feeling the sharp pain. He did not discuss it with medical personnel that day, because he was there specifically for the test and was not in the emergency room. He did not return to Dr. Partington to have the scan read because he was busy dealing with his work injury, but would have eventually followed up with the doctor to get the information if he needed another cortisone shot.

He first sought medical treatment on June 24, at Sentara Leigh Memorial Hospital (Sentara) emergency room. He testified that he waited that long because he had experienced back problems in the past and thought it might resolve on its own. However, after feeling a

stabbing pain, rather than an aching pain, and realizing it was not going away, he decided to go to the emergency room. His wife drove him to the hospital and provided his medical history to the nurses and physicians there because he was in a wheelchair and unable to help. Claimant testified that he did not tell the doctors any of the history on the emergency room report: that the “pain is associated with no known injury,” that the episodes started more than two days prior, that the problem had been constantly occurring, or that it had been gradually worsening since onset. His wife gave that information. Claimant testified that he told his wife on the 21st and 22nd about a sharp, stabbing pain but had not described to her what had happened to him at work.

Claimant had a pre-existing appointment for pain management and told Dr. Hansen about the injury during that appointment. The doctor said he could not treat Claimant because it was a work accident and he had to see a doctor in the hospital unless he had a workman’s comp agent. The doctor’s office told his wife that if he did not feel better in a few days, he needed to see someone for the pain.

Claimant wanted to see a new back doctor because Dr. Partington had not been able to help him much in the past. He wanted to see what another physician could offer him. Ronnie Allen, his union president, gave him the name of Dr. Wardell, and he went to see that doctor on July 7, 2010. Dr. Wardell examined Claimant and started him in physical therapy. He did very light stretches for the first 25 visits, and then took a benchmark test. He continued with slightly more demanding physical therapy like riding a bicycle, and eventually took the benchmark test again on December 8, 2010. That test showed drastic improvement from the first. In total, he had 48 physical therapy sessions and received some cortisone shots from Dr. Wardell.

Claimant testified that between June 21, 2010 and January 5, 2011, his back pain definitely improved. In the beginning, he could not sit, stand, or lie down for very long and had to constantly shift positions. He noticed slow, gradual progress over time: being able to sleep, stand up, sit down, and walk for longer periods of time.

Dr. Wardell released Claimant to return to full duty work on January 6, 2011. He returned to Employer on that date and has continued to work there, doing the same job in the same bay that he did prior to the aggravation. He testified that he has good and bad days but it is slowly getting better. During the week prior to the hearing, he had seen Dr. Wardell and was told everything looked pretty good and he did not need to follow up for three months.

Medical Records

Dr. Partington (CX 11, EX 4, EX 6)

July 17, 2008 – Initial visit

Claimant presented for neurological consultation at his own request due to low back pain. He reported that the pain had developed gradually over the last five years, rating it 9 out of 10 (9/10) in severity. He described the pain as aching, throbbing, constant and progressively worsening. It was not precipitated by any specific event and did not radiate. Claimant stated the pain was worst in the morning and night, interfering with sleep. Bending, lifting, prolonged sitting, and prolonged standing aggravated the pain. He had previously been treated with

physical therapy, chiropractic treatment, and NSAIDs. Of these, only chiropractic treatment was even transiently effective. Dr. Partington reviewed radiology reports and images. An MRI of the lumbar spine revealed degenerative disc disease (DDD) at multiple levels.

Physical examination revealed diffuse lumbar tenderness to palpation and decreased lumbar range of motion (“ROM”) in all planes. The doctor assessed lumbar spondylosis and ordered a lumbosacral series and bone scan.

July 31, 2008

Dr. Partington reviewed the July 18 radiology reports and images. The bone scan revealed facet arthropathy at L4-5 on the right. He confirmed his diagnosis of spondylosis and stated, “Patient is to remain out of work until he can get his lumbar facet injection.” He referred Claimant to Dr. Ton for that injection.

August 21, 2008

Claimant’s pain had improved to a 5/10 after a facet injection. His pain was aching and throbbing, but the injection temporarily brought relief. He denied radicular pain. “Given the very physical nature of his job, I feel he should remain out of work until his treatment is complete.” Dr. Partington referred Claimant to Dr. Ton for another L4-5 facet injection as well as a right L4-5 radiofrequency (RF) lesion.

September 25, 2008

Claimant’s pain had improved to a 2/10 after another facet injection. The doctor noted that Claimant was markedly better following the injections. “I have released him to return to work and will see him in three months.”

April 16, 2009

Claimant returned due to increasing back pain without radiculopathy. Neurologic examination was intact, but ROM of the back was somewhat restricted. Lumbar radiographs taken on this date showed no instability. Dr. Partington assessed increasing mechanical back pain and ordered a return to physical therapy with follow up in one month.

May 14, 2009

Claimant’s symptoms were gradually worsening low back pain and paresthesias (radicular pain) in the right leg. The aching, throbbing pain rated at 7/10. The paresthesias in the right leg, localized to the right L5 distribution, were a new symptom that had developed one month earlier. Physical therapy had not relieved the pain. Physical examination revealed 4+/5 L5 weakness. Dr. Partington assessed lumbosacral radiculopathy; R/O lumbar disc herniation at L4-5. He ordered an MRI of the lumbar spine. Claimant was to remain out of work until the doctor could review the MRI and see him for follow up.

May 18, 2009 MRI of Lumbar Spine (EX 6 at 1-2)

Radiologist Dr. Adam Specht found minor multilevel disc pathology, but more significant facet arthropathy, particularly on the right at L4-5 where there was moderately severe active inflammation. This finding was considered “new” or “progressive” compared to a January 2008 MRI. He found chronic mild to moderate ventral spondylosis.

He also found that the combination of disc and facet pathology caused minor compromise of the left L5 nerve: at L4-5 there was marrow edema extending along the right L5 pedicle. There was a small quiet Schmorl's node with minor central endplate depression upper L5.

June 10, 2010

Claimant presented for follow up of a recurrence of previous symptoms, namely gradually worsening low back pain at a severity of 6/10. The pain was aching and throbbing and did not radiate. Claimant had been treated with NSAIDs, physical therapy, and epidural steroids. The physical therapy and steroids were ineffective. Physical examination showed increasing back pain with extension. The doctor ordered a bone scan.

June 23, 2010 Bone Scan (EX 6-3)

Dr. Gregory Bosh found a region of intense uptake within the lower lumbar spine at the right L4-5 facet joint. The degree of activity showed a marked increase from the bone scan of July 25, 2008. His impression was of interval worsening L4-5 arthropathy.

Southeastern Physical Therapy (EX 5)

Crystal Hodges, D.P.T., wrote a letter to Dr. Partington on April 21, 2009, summarizing Claimant's physical therapy plan. She noted that Dr. Partington had referred Claimant to her. Claimant reported a history of right-side low back pain since the motorcycle accidents of 2005. He denied radicular pain but did have a constant dull ache in the right side of his low back at a pain level of 3/10 on average and 9/10 at worst. He was currently out of work for 30 days until May 14, 2009 under doctor's orders.

His job requirements were: pushing, pulling, ascending and descending ladders, welding, lifting, and using hammers. Claimant stated that an x-ray and MRI revealed a previous fracture, L3-L5 bone spur, and arthritis. He had also had his "nerves burned" eight months prior in the low back, which significantly decreased his pain, but a similar treatment six weeks earlier had not helped. His pain increased with prolonged sitting and lying down, changing positions, mowing the grass, and some work-related tasks.

Physical examination showed tenderness to palpation in the right lumbar paraspinals. He was given a lumbar roll and home TENS unit. Ms. Hodges assessed chronic low back pain, and symptoms consistent with possible posterior derangement. She set goals for Claimant, including being able to lift 50 pounds from floor to waist, maintaining upright posture to be able to mow the grass, and reducing to a pain level of 3/10 at worst so he could complete an eight-hour day. Treatment was scheduled two to three times per week, for four to six weeks.

Dr. Ton (EX 8)

Dr. Martin Ton performed several procedures on Claimant upon referral from Dr. Partington. On August 5, 2008, he administered a facet injection to the right L4-5 to address lower back pain, moderate lumbar DDD, and L4-5 bilateral facet arthropathy confirmed by a bone scan.

On September 15, 2008, Dr. Ton performed an RF lesioning of the medial branch nerve, right side L4 and L3. This procedure was indicated by “lower back pain right hand side, lumbar facet arthropathy L4-5, lumbar DDD, [and] successful diagnostic facet injection L4-5 right side.”

On March 9, 2009, he repeated the RF lesion procedure on the same location.

Dr. Hansen (CX 9, EX 7)

November 6, 2009 – Initial visit

Dr. Partington referred Claimant to Dr. Hansen at the Center for Pain Management for care of continuing neck and back pain. His primary care physician was Dr. Robichaud.

Claimant reported an onset date of 2005 but also that he had struggled with slowly worsening low back pain for the past ten years. His continuous pain sometimes radiates into the right buttock, and was reduced by activity and increased by sitting or lying still for long periods. He described the pain as dull and aching. He rated the pain at an average of 4 or 5 out of 10, reaching 7 or 8 at its worst. He felt it was difficult for him to be effective at work due to “nagging and increasing” back pain, and rated it as completely interfering with all aspects of his life. He also had pain in the posterior neck. The pain was not much relieved by Vicodin, Percocet, Aleve, or Relafen. He had only experienced a 10% relief from pain in the last 30 days.

Claimant reported that his back and neck pain were aggravated by two motorcycle accidents in 2005. Claimant had undergone physical therapy at Greenbrier Parkway and an RF lesion, but saw no significant benefit from these methods. He felt the TENS unit and medial branch blocks administered by Dr. Ton were more helpful. An MRI taken May 18, 2009, showed DDD at several levels, active facet inflammation on the right at L4-5, and some facet disease at L3-4 and L2-3.

Physical examination of the lumbar spine showed a tendency to stand a bit flexed, pain bending beyond 90 degrees in flexion, pain produced by extension, some tightness and discomfort to palpation of the lumbar paraspinal muscles, and pain to deeper palpation particularly to the right of midline. The latter symptom was evocative of facet disease.

Dr. Hansen diagnosed degenerative lumbar spine disease and likely degenerative cervical spine problems. The back was the more significant problem, and his pain was increasing and limiting. Radiographic evidence showed DDD and active inflammation in the facet joints. Dr. Hansen suggested a facet injection and a sustained release analgesic, prescribing Ultram ER and Percocet.

Return visits

Claimant returned to Dr. Hansen on November 30, 2009, and once a month from January to December 2010. At these appointments the doctor managed pain medication, and monitored physical therapy. On December 8, 2009, lumbar facet injections were administered at right L3-4 and right L4-5 by Dr. Little, another physician at the Center for Pain Management. Dr. Little administered a second set of injections to the same areas on March 15, 2010.

In November 2009 Claimant rated his pain at an average of 2-3 out of 10 and up to 9/10 at its worst. At the June 2010 visit, he reported that he had injured his back at work, and his pain averaged 6/10 and reached 9/10 at its worst. On July 1, 2010, the pain was 6/10 at the least, 10/10 at the worst, and averaged 8/10. By November 15, 2010, he had finished physical therapy and his pain was averaging 3-4/10 and rating 6-7/10 at its worst. The physical therapy was helpful. By December 15, 2010, his pain was averaging a 2/10 and only 3-4/10 at its worst. He was back to physical therapy, which was helpful.

Sentara Leigh Memorial Hospital (CX 10, EX 6 at 4-11)

Claimant was admitted on June 24, 2010 at 10:19 a.m. complaining of severe low back pain. He reported worsening lower back pain with right groin pain for four days. He described the pain as stopping him in his tracks and feeling like his leg was going to give out.

The report states that the medical history was given to Dr. Richard Schreckengaust by the patient and spouse. The history showed a chronic problem, with the current episode starting more than two days prior. The problem had been occurring constantly and worsening gradually since onset. The pain was associated with no known injury. Stabbing pain was present in the lumbar spine and sacroiliac joint, radiating to the right thigh at a severity of 9/10. Stiffness and pain level were constant. Bending, twisting, and certain positions worsened the symptoms.

Dr. Schreckengaust noted past diagnoses of back pain, epilepsy, and seizure disorder. Physical examination revealed decreased ROM and tenderness. The doctor reviewed old medical records and previous radiology studies, including the 2009 MRI. The 2009 MRI showed active facet inflammation on the right at L4-5, including marrow edema extending along right L5 pedicle, minimal inflammation on the left, and minor multilevel disc pathology. The facet arthropathy was more significant, particularly at L4-5 where there was moderately severe active inflammation. The combination of disc and facet pathology caused minor compromise of the left L5 nerve. (CX 10, CX 12-18)

Pain medication, labs, and x-rays were administered. June 24, 2010 x-rays of the lumbar spine and hip showed no acute abnormalities. Two views of the spine showed mild scoliosis, narrowing of the disk space at L4/5 without interval change, and spurring at multiple levels. Dr. Robert Woolfitt found that there may be facet arthritis at L5-S1. The x-ray of the hip showed no diagnostic abnormality. (EX 6 at 4-5)

Claimant was discharged at 1:26 p.m. with instructions to follow up with pain services and Neurosurgery. His pain assessment on discharge was 10/10.

Dr. Wardell (CX 8)

July 7, 2010

Claimant came to Dr. Wardell for evaluation of low back pain radiating down the right leg. He reported the flange incident, his visit to Sentara, and a medical history of low back injury and pain management.

Physical examination revealed midline lumbar tenderness, right low paralumbar tenderness, and lumbar facet tenderness. Right sacroiliac joint tenderness reproduced Claimant's pain. He had moderate restriction of low back flexion, and straight leg raising was negative bilaterally. Dr. Wardell reviewed the June 24, 2010 x-rays from Sentara and ordered x-rays of his own. The June 24 x-rays showed some anterior spondylophyte formation at multiple levels. His own x-rays showed lateral and anterior osteophyte formation as well as some sclerosis about the SI joints and partial fusions. Dr. Wardell made provisional diagnoses of "lumbosacral spine strain aggravating a pre-existing injury" and right sacroiliac joint sprain. (CX 8-1) He recommended a trial injection to the right sacroiliac joint and physical therapy.

The doctor signed a work note keeping Claimant out of work until reevaluation in two to three weeks. (CX 8-21)

July 12, 2010

Claimant was symptomatic, with marked right sacroiliac joint tenderness reproducing his pain. An injection was administered to the right sacroiliac joint and physical therapy was to begin soon. Dr. Wardell signed a work note keeping Claimant out of work until reevaluation in two weeks, and excusing him "from work missed since July 22, 2010." (CX 8-22)

August 3, 2010 – Disability Claim Form completed by Dr. Wardell

On July 30, 2010, Claimant reported extreme low back pain. The diagnoses of lumbosacral spine sprain/strain and sacroiliac joint sprain were supported by marked midline lumbar pain and tenderness with positive Patricks test. The work restriction ("unable to work at this time") was supported by marked restriction of back flexion with extreme decreased ROM. Dr. Wardell was unable to determine at this time when he expected improvement in Claimant's functional capacity.

August 16, 2010 – Disability Claim Form completed by Dr. Wardell

Claimant was unable to work at this time, and Dr. Wardell expected no change in condition at the next appointment scheduled for September 10, 2010. Dr. Wardell had given medical advice, diagnosis or treatment for the conditions (lumbosacral spine sprain/strain and sacroiliac joint sprain) on July 7, July 12, July 27, and August 6, 2010. The symptoms first appeared on July 21, 2010 and the disability began on July 22, 2010. (CX 8-16)

September 10, 2010

Claimant had an appointment this day, and Dr. Wardell signed a work note keeping him out of work until reevaluation in one week. (CX 8-23) Other notes show Claimant was continuing pain management and that office and physical therapy notes were being faxed to CUNA Mutual. Some treatment records during this time appear to be missing from the record.

September 23, 2010

Dr. Wardell wrote a letter stating that Claimant was under his care for orthopaedic treatment for injuries sustained in a work injury of June 21, 2010, and that he also required pain management treatment.

October 1-11, 2010,

Notes show that Carrier approved 12 physical therapy visits but denied the requested Functional Capacity Evaluation.

October 12, 2010

Claimant still had pain in his lower back when sitting, lying down, or standing for longer than 15 to 20 minutes. Examination showed pain with trunk rotation and lateral bending to the right. Dr. Wardell noted right iliolumbar pain and tenderness, negative straight leg raising, and moderate restriction of low back flexion. X-rays were taken, which showed anterior spondylophyte formation at multiple levels. The doctor prescribed continued pain management, and authorization for right L4-5 and L5-S1 facet joint injections. Claimant was to remain out of work and return in one month.

October 20, 2010 – Attending Physician’s Supplementary Statement

Dr. Wardell completed this form for Alicare. He listed diagnoses of lumbosacral spine sprain, and sprain/strain of both the lumbar facet and sacroiliac joint. He described Claimant’s symptoms as “low back pain persists with sitting, standing, or lying down for longer than 15-20 minutes at a time.” His objective findings were: right iliolumbar pain/tenderness and moderate restriction of low back flexion. Claimant was currently taking pain management medication: Roxicodone, Opana ER, Amrix, and Ambien. He had treated for this disability on July 7, July 12, July 27, August 6, September 10, and October 12, 2010. Claimant had been unable to work due to the injury since July 22, 2010 and remained unable to work. (CX 8-17)

October 22, 2010

Dr. Wardell wrote a letter to Claimant’s counsel recommending Claimant undergo functional testing before starting additional physical therapy. The doctor explained the components of the testing and stated that it would establish a baseline to determine when Claimant reaches maximal benefit from the therapy. The doctor also noted that Claimant had been under his care since July 7, undergoing injections and physical therapy after he “incurred a lumbosacral spine sprain and right sacroiliac joint sprain on June 21, 2010.” (CX 8-9)

November 3, 2010

Claimant reported very little improvement in his day-to-day pain, though he felt therapy was helping somewhat. The injections gave him relief from his pain for several weeks. Examination showed right sacroiliac joint tenderness, right paralumbar tenderness, and a positive straight leg raise on the right at 70 degrees for right low back pain. Claimant told Dr. Wardell that he had taken occasional pain medication for his back prior to the June 21, 2010 injury. He reported that he worked full duty until June 21, 2010, but after that date his pain increased markedly and he had been unable to work.

November 4, 2010

In response to a request from Employer, Dr. Wardell wrote a letter stating that, according to his medical history, prior to June 21, 2010 Claimant was working full duty and taking pain medication infrequently as needed. After that date, his symptoms worsened and he had been unable to work. (CX 8-11)

November 10, 2010 – Attending Physician’s Supplementary Statement

Dr. Wardell completed another form for Alicare. He listed the same diagnoses as the October 20 form, adding that the lumbar facet strains were at L4-5 and L5-S1. Claimant’s symptoms remained the same, but he added that Claimant had noted some improvement with physical therapy. His objective findings were tenderness at the right sacroiliac joint and right paralumbar, as well as positive straight leg raising of low back pain at 70 degrees. Pain medications were unchanged. He added treatment dates of November 3 and November 10, 2010. Claimant remained unable to work. (CX 8-18)

November 11, 2010

Claimant reported some improvement but was not at his pre-injury level. Straight leg raise and tenderness were unchanged from November 3. Claimant had mild restriction of low back flexion. Physical therapy was to continue with functional testing and Claimant was to return in two weeks.

November 17, 2010

In response to a separate request from Employer, Dr. Wardell wrote a letter opining:

Although [Claimant] may reach his pre-injury status over time and with continued treatment, as of this time, he has not, and I am concerned he may not reach his pre-injury status. At this point, and to a reasonable degree of medical certainty, I think he will have flare-ups of his current condition.

(CX 8-13)

November 30, 2010

Claimant had two weeks of physical therapy remaining. He reported continued pain in the low back, especially on the right. Examination revealed pain with trunk rotation and lateral bending to the right, moderate restriction of low back flexion, right iliolumbar and paralumbar pain and tenderness, and negative straight leg raising. Injections were administered to the L4-5 and L5-S1 facet joints. Claimant was to be fitted for lumbar orthosis and remain out of work for two weeks. “Possible return to work duties at that time.” (CX 8-3)

December 1, 2010 – Attending Physician’s Supplementary Statement

Dr. Wardell completed another form for Alicare. He listed the same diagnoses as the November 20 form. Claimant’s symptoms were low back pain mainly on the right side. His objective findings were pain with trunk rotation and lateral bending to the right, and moderate restriction of low back flexion with right side iliolumbar and paralumbar pain. Pain medications were unchanged. He added the treatment date of November 30, 2010. Claimant remained unable to work, with a follow up appointment scheduled in two weeks. (CX 8-19)

December 9, 2010 Benchmark Evaluation

Claimant demonstrated improvement in lumbar spine ROM and overall strength since last evaluation on September 20, 2010. The doctor stated Claimant might benefit from brief continuation of therapy for spine stabilization exercises and then move to a home exercise program. Claimant would be re-assessed at the end of his current prescription.

December 14, 2010

Claimant had seven sessions of therapy remaining and felt his motion was improving. He was working on improving his strength. Examination revealed mild restriction of lower back flexion, mild right paralumbar pain and tenderness, and negative straight leg raising. There was no pain with trunk rotation and lateral bending to the right or left. "He will finish physical therapy. He will remain out of work and return in one month."

January 4, 2011

[Claimant] has completed physical therapy. He states he is doing slightly better. He informs me that he would like to attempt to return to full work duty. Examination reveals a mild restriction of lower back flexion. He has no pain or restricted motion with trunk rotation to the right or to the left. There is some mild discomfort noted with back extension beyond 10 degrees with negative straight leg raising. [Claimant] will attempt to return to full work duty on January 6, 2011. He will return to see Dr. Wardell in one month.

(CX 8-4; EX 9)

January 31, 2011

Dr. Wardell reviewed Dr. Skidmore's two reports, the June 23, 2010 bone scan, and the August 3, 2010 MRI, and wrote a letter on January 31, 2011. He compared the more recent scan and MRI with the pre-trauma bone scan and MRI. Dr. Wardell opined:

The findings of his studies post-injury are remarkable for a significant increased uptake of technetium on the bone scan inflammation and edema over the L4-5 facet joint compared to the MRI findings of May 19, 2009. Contrary to Dr. Skidmore's opinion that these change were due to a gradual worsening of [Claimant's] degenerative condition, I think it is more likely than not to represent post-injury changes based on the history provided by [Claimant].

(CX 8-8) He enclosed his notice and statement of Lien in the amount of \$12,088.95.

Dr. Skidmore (CX 7, EX 1)²

Claimant saw Dr. Grant Skidmore only once, on November 2, 2010, for evaluation at Employer's request. The doctor wrote a report that day based on physical examination; a review of medical records from Drs. Partington, Ton, and Wardell; a review of MRIs, bone scans, and physical therapy records; and taking a medical history. He supplemented his report on December 14, 2010. He was deposed on February 1, 2011.

November 2, 2010 report

Dr. Skidmore reported that Claimant, a 46-year-old man, relayed the details³ of straightening the flange and the pry bar slipping, and that he noticed sharp pain in his low back

² The deposition and hearing testimony overlap significantly and are consolidated for the sake of economy.

³ I note these details are precisely consistent with Claimant's testimony as to order of events and particulars of the pry bar, flange, etc.

while driving home. The pain was markedly worse two to three hours later, and radiated into his right leg. The next morning after trying to work for an hour, he could not work. He had never felt this level of pain before and could barely move. He stayed on bed rest for two days and then went to the emergency room.

Dr. Skidmore noted that Dr. Partington's notes from the June 10, 2010 visit included the doctor's assessment that Claimant had gradually worsening pain rated at 6/10, with a throbbing, aching quality that did not radiate. Dr. Skidmore summarized Claimant's medical history as reflected in his medical records. He noted Dr. Partington's treatment going back to July 2008 and his diagnoses of facet arthropathies, specifically the right L4-5 facet. A bone scan supported this finding, and an MRI had revealed DDD. Claimant had received facet injections from Dr. Ton for about four months in 2008 and then was able to return to work.

Claimant reported continued episodes of back pain over the years but did not have to leave work for pain since the initial period in 2008. Dr. Skidmore noted that the records showed Claimant was out of work when he initially saw Dr. Partington and was released back to work in August 2008. The pain continued to improve and was down to 2/10 by September. Claimant returned to Dr. Partington in April 2009 and returned to physical therapy, however in May 2009 the pain had worsened and was radiating into the right leg. Dr. Partington sent Claimant for an MRI, which revealed moderately severe active inflammation of the right L4-5 facet joint, as well as a compromise of the left L5 nerve root, caused by a combination of disc and facet pathology. Dr. Partington took Claimant out of work for a short period of time, and Claimant saw a chiropractor for the rest of 2009. He returned to Dr. Partington on June 10, 2010 for recurrence of previous symptoms without radicular pain to the leg.

Dr. Wardell's record of the July 7, 2010 appointment reflected the flange incident. Dr. Wardell diagnosed a lumbosacral spine strain aggravating a pre-existing injury and right sacroiliac joint strain. The doctor administered a right sacroiliac joint injection on July 12 and sent him for an MRI. The August 3, 2010 MRI showed remarkable inflammation and edema at the right L4-5 facet and adjacent posterior element marrow edema. The radiologist Dr. Reeding stated this MRI showed similar inflammation to the 2009 MRI.

Claimant reported to Dr. Skidmore that he had not worked since the June 21 incident and that his back pain persisted but his leg had improved under Dr. Wardell's treatment. He had no current leg pain. Claimant expressed that physical therapy was beginning to help and he was glad he opted to go through it. Claimant did not feel he could work on November 2, 2010 due to the severity of his pain. He reported that this was the worst exacerbation he has had, and he was markedly limited. He could not cut his grass or work on his car.

Physical examination revealed "much in the way of mechanical back pain with moving around the room." (CX 7-12) He had limited ROM in the lumbar spine, 2+ reflexes on the knees, 1+ reflex at the ankles, and a negative straight leg raise bilaterally. Bending forward and backward caused much pain. Dr. Skidmore did not conduct any diagnostic tests, but reviewed the 2009 and 2010 MRI reports, which showed clear "inflammation about the right facet joint and into the adjacent tissue. There is a small synovial cyst and a foraminal disc protrusion on the right side." *Id.* Claimant was neurologically intact.

Dr. Skidmore's assessment in response to the question "Does the patient have a new back injury?" is as follows:

Certainly, it does appear that he suffered a lumbar strain with the incident of June 21st. He is very specific about the incident and the mechanism of injury. He clearly has a past history of problems with the facet joint L4-5 on the right and Dr. Partington further defined this with a bone scan which happened to be performed 2 days after the incident. Clearly, the patient was having problems in early June that [led] him back to Dr. Partington. I do, therefore, think that [in] the 3 months following the incident of June 21[,]treatment was necessary for that incident, but that he is at his baseline prior status.

(CX 7-13). Dr. Skidmore opined that generally treatment had not changed after June 21, based on a review of Dr. Hansen's records. Exceptions to this general statement were the injections and physical therapy administered by Dr. Wardell, which were appropriate to address the June 21 incident.

Dr. Skidmore recommended that Claimant return to Dr. Partington for further evaluation. "It is possible that surgical intervention could be entertained, specifically because of the marked facet joint disease, edema, and inflammation that is noted at L4-5 on the right and perhaps a fusion could be considered." He concluded,

It may be necessary that the patient change his heavy manual labor type of work in the future with these [periodic] exacerbations that he has, but I do think that this is not related and the need for changing his job is not related to this most recent incident specifically, but the pre-existing condition that he has.

Id.

December 14, 2010 report

Dr. Skidmore supplemented his report after reviewing "further material concerning my assessment of Claimant's case." (CX 7-2) In the second report, the doctor stated that the "long-standing disorder...has progressively worsened through the years and is completely and totally, absolutely separate, from the very minor mechanism of injury, straining his lumbar spine possibly through the course of the workday on June 21, 2010." *Id.*

There is no description of what "further material" the doctor reviewed. Attached to the second report are copies of the 2008, 2009, and 2010 MRIs, as well as the 2010 bone scan, all of which he had already reviewed prior to his November report. The doctor testified in his deposition that he had not actually seen any new material, but was clarifying his opinion using the records he had already reviewed to inform his initial report. He testified that he had no reason to question the history given him by Claimant. He did not believe there were any inconsistencies between his two reports.

Deposition Testimony (EX 2, EX 3)

At a deposition taken on February 1, 2011, Dr. Skidmore testified that he had practiced as a neurosurgeon with his current group for 16 years and specialized in back operations. Dr. Partington is one of his partners. Dr. Skidmore is Board-certified in Neurosurgery.

Dr. Skidmore hypothesized that Dr. Partington would have ordered the June 2010 bone scan in order to determine whether the recurrence of previous symptoms was due to the same problem identified in the 2008 bone scan; namely the severe disease of the facet joint at the L4-5 space on the right. Dr. Skidmore's review of both bone scan reports showed some worsening through the years of that specific facet joint. He would expect that arthritic condition to worsen progressively over time. He testified that it would be impossible to determine from a bone scan whether a recent event caused any worsening. Comparing MRIs can help determine whether acute changes have occurred over time. His comparison of the 2009 and 2010 MRIs led him to the conclusion that they were similar in appearance and no acute change had occurred. Dr. Skidmore stated that the notes from Dr. Partington's July 2008 examination of Claimant were similar to his own in that they both found Claimant to be neurologically intact, and both showed mechanical findings.

With respect to his November 2, 2010 diagnosis of a lumbar strain, he testified that he would have expected such a strain to resolve within three months, depending on the severity of the strain. Claimant's injury was a minor mechanism of straining, which would take a maximum of three months to return to baseline. With respect to his November 2 conclusion that Claimant "was at baseline prior to status," Dr. Skidmore admitted that this conclusion was not based on any physical findings. Rather, it was based on the history given by Claimant, taken together with the similarities in neurological findings between Dr. Partington's 2008 exam and Dr. Skidmore's 2010 exam.

Dr. Skidmore testified that he attributed none of the symptoms of November 2 to the June 21 incident. He stated that he issued the second report in December because he had been asked to clarify his opinion. He could not recall who asked him, but the opinions were addressed to Ms. Cindy Wilson. He did not review any additional records. He concluded that the June 21 incident did not cause any further pathology, based on his opinion that the bone scan and MRI showed the same disease process that had been diagnosed before.

Dr. Skidmore stated that the second bone scan showed worsening facet arthropathy because there was more uptake of the tracer. A bone scan could not show worsening of a lumbar strain because that injury involves tissue or muscle, neither of which is visible in the scan. The most recent MRI showed that the DDD had worsened since the prior MRI.

The doctor opined that the June 21 incident caused a three-month exacerbation and nothing more. He believed the TENS unit was appropriate treatment for the strain that occurred in June. However, use of the TENS after the first three months that would be needed to resolve the strain would be the result of the underlying condition. Dr. Skidmore also believed that the prescription of pain killers or muscle relaxers would be the result of the underlying condition.

The doctor opined that the pre-existing condition “makes him more prone to have exacerbations of pain, but not to have an injury necessarily.”

The doctor testified that the disease at L4-5 is “certainly worsening and over time will probably result in surgery and so I think that he has further treatment in his future almost for sure.” He speculated that a fusion or elimination of the joint might be necessary. Dr. Skidmore testified that “[o]ver time, as the degenerative process continues, the conservative measures that work for a period of time, such as injections and medications, begin to wear off and lose their effect and then subsequently surgery enters into the picture.” He believed it was the exception for an injury to lead to this kind of surgery. The surgery becomes necessary when the pain can no longer be managed by more conservative measures.

Dr. Skidmore commented that it was remarkable that Claimant had been continuing on with his work considering the significance of the problem identified by Dr. Partington. He held to his opinion that Claimant may need to change his type of work in the future to something with less heavy labor. However, he also stated that he had no reason to believe Claimant would re-injure himself, so long as the longstanding problem and pain were treated properly.

Notice of Lien

A letter from Hampton Roads Shipping Association – International Longshoremen’s Association (HRSA-ILA), dated February 10, 2011, states that between August 12, 2010 and January 20, 2011, the HRSA-ILA Welfare Fund made total payments of \$15,375.00 to Claimant, pursuant to § 17 of the Act. The Notice is attached to a Certification of Continuing Disability Benefits. “If Worker’s Compensation benefits are awarded, we request that you issue an order to enforce our Worker’s Compensation lien.”

DISCUSSION

I. Claimant’s injury is compensable under the Act

Section 2(2) of the Act defines “injury” as an “accidental injury or death arising out of or in the course of employment . . . or as naturally or unavoidably results from such accidental injury.” 33 U.S.C. § 902(2) (2006). A work-related aggravation of a pre-existing condition is an “injury” pursuant to Section 2(2) of the Act. *Gardner v. Bath Iron Works Corp.*, 11 BRBS 556 (1979), *aff’d sub nom. Gardner v. Director, OWCP*, 640 F.2d 1385, 13 BRBS 101 (1st Cir. 1981); *Preziosi v. Controlled Industries*, 22 BRBS 468 (1989); *Johnson v. Ingalls Shipbuilding*, 22 BRBS 160 (1989); *Madrid v. Coast Marine Construction*, 22 BRBS 148 (1989).

Section 20(a) of the Act provides a claimant with a presumption that his condition is causally related to his employment if he establishes a *prima facie* case by proving that he suffered a harm and that employment conditions existed or a work accident occurred which could have caused, aggravated, or accelerated the condition. *See U.S. Industries/Federal Sheet Metal v. Director, OWCP [Riley]*, 455 U.S. 608, 615, 14 BRBS 631, 633 (1982), *rev’g Riley v. U.S. Industries/Federal Sheet Metal*, 627 F.2d 455, 12 BRBS 237 (D.C. Cir. 1980).

If the claimant invokes the presumption, the burden shifts to the employer to rebut the presumption with substantial countervailing evidence. *Swinton v. J. Frank Kelly Inc.*, 554 F.2d 1075, 1081, 4 BRBS 466, 474–75 (D.C. Cir. 1976), *cert. denied*, 429 U.S. 820 (1976). If the presumption is rebutted, it falls out and the administrative law judge must weigh all the evidence and render a decision that is based on the record as a whole. *See id.* at 1082 n.35, 4 BRBS at 476 n.35. This rule is an application of the “bursting bubble” theory of evidentiary presumptions, derived from the Supreme Court’s interpretation of Section 20(d) in *Del Vecchio v. Bowers*, 296 U.S. 280 (1935). *See Brennan v. Bethlehem Steel Corp.*, 7 BRBS 947 (1978) (applying *Del Vecchio* to Section 20(a)).

Claimant has invoked the § 20(a) presumption

A claimant’s subjective complaints of symptoms and pain can be sufficient to establish the element of physical harm if such complaints are found credible. *Sylvester v. Bethlehem Steel Corp.*, 14 BRBS 234, 236 (1981). Additionally, it is well established that the claimant does not need to introduce medical evidence affirmatively connecting his harm to his employment in order to establish his *prima facie* case. *See, e.g., Ramey v. Stevedoring Services of America*, 134 F.3d 954, 31 BRBS 206(CRT) (9th Cir. 1998); *Hampton v. Bethlehem Steel Corp.*, 24 BRBS 141 (1990).

In this case, Claimant has established that he suffered a harm. Specifically, Claimant testified that he experienced an aggravation of low back and right leg pain following the incident with the slipping pry bar on June 21, 2010. Claimant’s testimony is supported by the medical records from Drs. Hansen and Wardell, Sentara, and even Dr. Skidmore confirmed that the June 21 incident resulted in a lumbar strain and aggravation.

Claimant’s subjective complaints of pain rising to the level of 9-10/10 in the days following the accident, resulting in an inability to work, are uncontroverted and supported by the record. On July 2, 2010, Dr. Hansen refused to treat Claimant because he recognized that his office did not have permission to treat this new workers’ compensation injury.

Claimant must also establish that employment conditions existed or a work accident occurred which could have caused, aggravated, or accelerated his back condition. All accounts of Claimant’s work with the pry bar slipping as he straightened the flange are extremely consistent, from Claimant’s testimony to the details reported to Drs. Wardell and Skidmore. Employer submits no evidence contradicting these events. There is no reason to doubt Claimant’s credibility and therefore I find that the repeated jolting of his body is a work accident which could have aggravated or accelerated his back condition.

Therefore, I find that Claimant has invoked the presumption because he suffered a harm (lumbar strain, pain, and associated radiculopathy) and that a work accident occurred (pry bar slipping) which could have caused the harm.

Employer has not rebutted the 20(a) presumption

Once the presumption is invoked, Section 20(a) places the burden on the employer to come forward with substantial countervailing evidence to rebut the presumption that the injury was caused by the claimant's employment. *Swinton*, 554 F.2d at 1081, 4 BRBS at 474–75. The United States Supreme Court has defined “substantial evidence” as “more than a mere scintilla” or “such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.” *Richardson v. Perales*, 402 U.S. 389, 401 (1971); *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 477 (1951). Where aggravation or contribution to a pre-existing condition is alleged, employer must establish that a claimant's condition was not caused or aggravated by his employment. *Cairns v. Matson Terminals*, 21 BRBS 252 (1988).

Employer relies on Dr. Skidmore's medical report and various medical records to assert that Claimant's disability and medical treatment are related to his pre-existing condition, and were *not* aggravated by the events of June 21, 2010. Alternately, Employer argues that if the pre-existing condition was aggravated, the injury had completely resolved within three months of its inception.

The evidentiary record clearly establishes that Claimant had a pre-existing back problem, for which he was treated by Drs. Partington, Ton, and Hanson before June 21, 2010. This fact is undisputed.

Dr. Skidmore, the physician to whom Claimant was sent by Employer, initially opined in his November 2010 report: “Certainly, it does appear that [Claimant] suffered a lumbar strain with the incident of June 21st. He is very specific about the incident and the mechanism of injury.” Dr. Skidmore went on to state that Claimant may need to change to a job with a lower level of heavy labor, but clarified that this is related solely to the pre-existing condition, and not to the June 21 event. In December 2010 Dr. Skidmore issued a second report based on no new information. He stated that Claimant's “long-standing disorder...has progressively worsened through the years and is completely and totally, absolutely separate, from the very minor mechanism of injury, straining his lumbar spine possibly through the course of the workday on June 21, 2010.” *Id.*

The underlying premise of Dr. Skidmore's opinion, then, is that a lumbar strain *did* occur on June 21 but it was minor, but it should have resolved within three months. He goes on to opine that the progressive worsening of Claimant's condition is to be expected over time in someone with Claimant's arthritic condition, and is in no way related to the work accident of June 21.

However, the Board has held that “[w]hether the circumstances of a claimant's employment combine with the pre-existing condition so as to increase her symptoms to such a degree as to incapacitate her for any period of time or whether they actually alter the underlying process is not significant.” *L.W. v. Northrop Grumman Ship Sys., Inc.*, 43 BRBS 27, 34 n.18 (Mar. 27, 2009) (citing *Gooden v. Director, OWCP*, 135 F.3d 1066, 32 BRBS 59(CRT) (5th Cir. 1998)). The aggravation rule provides that where an injury at work aggravates, accelerates or combines with a prior condition, the entire resultant disability is compensable. *Strachan Shipping*

Co. v. Nash, 782 F.2d 513, 18 BRBS 45(CRT) (5th Cir. 1986) (*en banc*). This rule applies not only where the underlying condition itself is affected but also where the injury “aggravates the symptoms of the process.” *Pittman v. Jeffboat, Inc.*, 18 BRBS 212, 214 (1986). All of the physicians of record opine that Claimant’s symptoms were aggravated, even if only temporarily, on June 21.

Employer points to the medical history given at Sentara hospital on June 24 by Claimant’s wife to suggest that the onset of symptoms occurred earlier. However, Claimant explained this discrepancy by noting that he did not provide the history to the doctor, and his wife was not aware of the June 21 flange incident. Further, Claimant’s description of the chronology of his symptoms, especially the severe worsening that led him to stay on bed rest June 22 and 23, are consistent throughout the record. I find Claimant’s testimony credible regarding the onset of his symptoms.

I find that Employer has failed to rebut the presumption that Claimant’s condition was not aggravated by the events of June 21. Dr. Skidmore clearly testified in his deposition and stated in his reports that on June 21 the condition was *at least* aggravated by a minor strain. Employer has proffered no substantial evidence supporting the notion that Claimant’s pre-existing back condition was not at least aggravated by the work accident.

Claimant is entitled to the presumption that the aggravation of his pre-existing back condition was causally related to his employment, and is therefore compensable under the Act.

II. Claimant is entitled to TTD payments from June 21, 2010 through January 5, 2011

Neither party is contending that Claimant is permanently disabled, or that any disability has continued after January 5, 2011. Claimant is seeking temporary total disability⁴ payments from June 21, 2010 to January 5, 2011, but Employer asserts that because the injury resolved by September 21, 2010, any TTD payments should cease at that date.

The issue is whether the exacerbation of the pre-existing condition resolved on September 21, 2010 or January 5, 2011. Claimant asserts that it resolved on January 5, 2011, when Dr. Wardell released Claimant to full-time work. Employer asserts that it resolved no later than September 21, 2010, three months from the date of injury.

Claimant was kept out of work by Dr. Wardell from his first appointment on July 7, 2010 through January 5, 2011. During that time Dr. Wardell’s treatment notes show a pattern of determining that Claimant was unable to return to work, scheduling a follow up visit, and stating that Claimant was to remain out of work until the doctor re-evaluated his condition at the next

⁴ The date of maximum medical improvement (MMI) is the traditional method of determining whether a disability is permanent or temporary in nature. *See id.*; *Turney v. Bethlehem Steel Corp.*, 17 BRBS 232, 235, fn. 5, (1985). The date of MMI is the date on which the employee has received the maximum benefit of medical treatment such that his condition will not improve. This date is primarily a medical determination. *See Mason v. Bender Welding & Mach. Co.*, 16 BRBS 307, 309 (1984). Until medical evidence establishes that the Claimant’s injury has reached MMI, the work-related injury is temporary in nature. After MMI is achieved, the work-related injury is permanent in nature. No physician of record has issued an opinion regarding MMI, nor has either party suggested that Claimant’s condition cannot improve from medical treatment. I find that Claimant’s injury is temporary in nature.

appointment. On September 23, 2010, two days after Employer argues the injury should have resolved, Dr. Wardell noted that pain management was needed and that Claimant was continuing under his orthopaedic care. In October 2010 Claimant was consistently attending physical therapy, and Employer refused to authorize a Functional Capacity Evaluation that was recommended by Dr. Wardell.

Dr. Wardell saw Claimant nearly once a week in November 2010. Claimant initially reported very little improvement in his day-to-day pain, but was continuing with pain management and physical therapy. Later in the month he reported some improvement but was not at his pre-injury level. On November 17, 2010, Dr. Wardell wrote to Employer, stating, “Although [Claimant] may reach his pre-injury status over time and with continued treatment, *as of this time, he has not*, and I am concerned he may not reach his pre-injury status. At this point, and to a reasonable degree of medical certainty, I think he will have flare-ups of his current condition.” (CX 8-13)(emphasis added) On November 30, Dr. Wardell showed some optimism in his treatment note, stating that it may be possible for Claimant to return to work duties in two weeks after his next follow-up appointment. On December 1, he confirmed with Alicare that Claimant remained unable to work at the present time.

At the December 9 benchmark evaluation Claimant showed improvement in lumbar spine ROM and overall strength since September 20, 2010. On December 14, Claimant himself felt his motion was improving due to physical therapy. After examination, Dr. Wardell determined Claimant should remain out of work for one month as he completed physical therapy and worked on improving his strength.

On January 4, 2011, Dr. Wardell wrote, “[Claimant] has completed physical therapy. He states he is doing slightly better. He informs me that he would like to attempt to return to full work duty.” The doctor released him to do so, returning him to full work duty on January 6, 2011.

This evidence from Claimant’s treating physician shows a clear path of a patient’s recovery and his doctor’s careful monitoring thereof. Dr. Wardell consistently evaluated Claimant’s condition, pain, and ability, and prescribed an appropriate follow-up period based on his medical judgment. Claimant himself asked to return to work full time after he completed physical therapy. This timeline dovetails with Claimant’s own testimony regarding his slow, gradual progress over time and the improvement he experienced through physical therapy.

Further, the records from his pain management specialist, Dr. Hansen, reflect the same timeline. Ten days after the June 21 accident, Claimant’s pain was 10/10 at the worst, and averaged 8/10. By November 15, 2010, he had finished physical therapy and his pain was averaging 3-4/10 and rating 6-7/10 at its worst. Dr. Hansen noted that the physical therapy was helpful. By December 15, 2010, his pain was averaging a 2/10 and only 3-4/10 at its worst. Again, the records show a gradual progression of declining pain and improvement with physical therapy. Notably, this recovery was still taking place in November and December of 2010, well after Employer’s asserted resolution date of September 21, 2010.

Employer's argument that the minor aggravation should have resolved within three months is based on the opinion of Dr. Skidmore. Dr. Skidmore saw Claimant once, on November 2, 2010. At that time, Claimant expressed that physical therapy was *beginning* to help but he did not feel he could work yet due to the severity of his pain. He reported that this was the worst exacerbation he has had, and he was markedly limited. Dr. Skidmore's physical examination showed "much in the way of mechanical back pain with moving around the room," limited ROM in the lumbar spine, 2+ reflexes on the knees, 1+ reflex at the ankles. Bending forward and backward caused much pain.

This examination took place roughly six weeks after the date on which Dr. Skidmore thought that the aggravation should have resolved. However, Dr. Skidmore opined that Claimant was "at his baseline prior status." The doctor admitted in his deposition that this conclusion was not based on any physical findings. Rather, it was based on the history given by Claimant, taken together with the similarities in neurological findings between Dr. Partington's 2008 exam and Dr. Skidmore's 2010 exam.

Dr. Skidmore reasoned that because his findings were similar to those of Dr. Partington in 2008, Claimant had returned to that baseline. He attempted to bolster this argument by stating that treatment of Claimant had not changed after June 21, but also acknowledged that after June 21, Claimant underwent facet injections and extensive physical therapy. Dr. Skidmore noted that the diagnostic tests of 2008, 2009, and 2010 all showed progressive worsening of the facet arthropathy and DDD, but he attributed this to the pre-existing condition only and insisted that it was not related in any way to June 21.

The doctor opined that the pre-existing condition "makes him more prone to have exacerbations of pain, but not to have an injury necessarily." This opinion is not consistent with the Act, which states that a work-related aggravation of a pre-existing condition is, in fact, an "injury" pursuant to Section 2(2).

Treating Physician

In determining the weight to be given to conflicting medical opinions, one factor that may be considered is whether a physician rendering an opinion is the claimant's treating physician. The Fourth Circuit, whose authority is controlling in this case, has stated that a treating physician is entitled to "great, though not necessarily dispositive weight." *Grigg v. Director, OWCP*, 28 F.3d 416, 420 (4th Cir. 1994) (citing *Grizzle v. Picklands Mather & Co.*, 994 F.2d 1093, 1097 (4th Cir. 1993)); *Hubbard v. Califano*, 582 F.2d 319, 323 (4th Cir. 1978)). Dr. Wardell was Claimant's treating physician for six months, beginning ten days after the June 21 injury, saw him numerous times, and issued him work restrictions. Accordingly, in forming his opinion, he had the benefit of observing Claimant's condition over an extended period of time. His records and letters also reflect a more comprehensive understanding of Claimant path to recovery than that of Dr. Skidmore. Further, his opinion is corroborated by Claimant's testimony and Dr. Hanson's treatment notes.

Although Dr. Skidmore engaged in a detailed review of Claimant's medical records, he examined Claimant only once. His opinion regarding Claimant's baseline status is not founded on any physical findings, but on general predictions for a minor strain. Dr. Skidmore claims to

base his opinion on the history provided by Claimant and medical records, but his opinion contains some troubling contradictions. Dr. Skidmore testified that he had no reason to question the history given him by Claimant, but goes on to ignore Claimant's direct report that while physical therapy was beginning to help, he was in too much pain to return to work on November 2. He also glosses over the new treatments prescribed after June 21 which would contradict his assertion that the treatment generally had not changed since the flange incident. Finally, his opinion suggests that he views aggravations and injuries as mutually exclusive events, which is contrary to the legal definitions established in the Act and in case law. These contradictions lead me to accord less weight to the opinion of Dr. Skidmore.

Taking all of the above together, I find that Dr. Wardell's opinion is more persuasive than that of Dr. Skidmore. Dr. Wardell's opinion is entitled to weight as Claimant's treating physician, is supported by the evidence of record, and is well-reasoned. Accordingly, I find that the exacerbation of Claimant's back condition resolved on January 5, 2011.

TTD Payments

The Act provides that where the claimant's injury results in more than 14 days of disability, compensation shall be allowed from the date of disability. 33 U.S.C. § 906(a). Claimant was out of work due to disability for more than 14 days; therefore, he is entitled to TTD benefits from June 21, 2010, his date of disability, through January 5, 2011. Section 8(b) of the LHWCA provides:

Temporary total disability: In case of disability total in character but temporary in quality 66 2/3 per centum of the average weekly wages shall be paid to the employee during the continuance thereof.

33 U.S.C. § 908(b). The parties stipulated that Claimant's pre-injury AWW was \$959.79, resulting in a compensation rate of \$639.86. Accordingly, Claimant is entitled to TTD benefits at a compensation rate of \$639.86 per week from June 21, 2010 through January 5, 2011.

Medical Care

Section 7(a) of the Act provides that, "[t]he employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require." 33 U.S.C. § 907(a) (2006). Accordingly, the employer is liable for all reasonable and necessary medical expenses arising from a claimant's work-related injury. *Pernell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979). Medical care should also be appropriate for the injury. 20 C.F.R. § 702.402 (2009). In this case, Claimant has established that his low back and associated radiculopathy arose out of and in the course of his employment. Accordingly, I find that Claimant is entitled to all past, present, and future appropriate, necessary, and reasonable medical expenses associated with these injuries.

CONCLUSION

I have determined the following based on a complete review of the record in light of the arguments of the parties, testimony of the witnesses, applicable statutory provisions, regulations, and pertinent precedent. Claimant has proven by a preponderance of the evidence that his low back pain and associated radiculopathy are causally related to his employment. Additionally, Claimant has established that he is entitled to TTD benefits from June 21, 2010 through January 5, 2011. Finally, Claimant is due and payable medical expenses relating to his low back pain and associated radiculopathy, as allowable under Section 7.

ORDER

1. Employer shall pay Claimant temporary total disability payments from June 21, 2010 through January 5, 2011, at the rate of \$639.86 per week.
2. Employer is responsible for past, present, and future medical treatment of Claimant's work injuries in accordance with Section 7 of the Act.
3. Employer shall deduct the amount of the HRSA-ILA Welfare Fund's lien (\$15,375.00) from the disability payments paid to the Claimant and pay that sum directly to the HRSA-ILA Welfare Plan.
4. Interest at the rate specified in 28 U.S.C. § 1961 in effect when this Decision and Order is filed with the Office of the District Director shall be paid on all accrued benefits computed from the date each payment was originally due to be paid. *See Grant v. Portland Stevedoring Co.*, 16 BRBS 267 (1984).
5. All computations are subject to verification by the District Director.
6. Should Claimant's counsel seek attorney fees and legal costs associated with this case, Claimant's counsel, within twenty (20) days of receipt of this Order, shall submit a fully documented fee application, a copy of which shall be sent to opposing counsel, who shall then have twenty (20) days to respond with objections thereto.

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KENNETH A. KRANTZ
Administrative Law Judge

Newport News, Virginia
KAK/lec/mrc