U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 09 January 2013

Case No: 2012-LHC-00768

OWCP No: 05-109714

In the Matter of:

STANLEY E. JOHNSON,

Claimant,

v.

HUNTINGTON INGALLS INDUSTRIES, INC.,
(Self-Insured),

Employer/Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,

Party-In-Interest.

APPEARANCES: Ralph Rabinowitz
Attorney for the Claimant

Jonathan H. Walker
Attorney for the Employer

BEFORE: ALAN L. BERGSTROM
Administrative Law Judge

DECISION AND ORDER -- DENYING BENEFITS

This proceeding arises from a claim filed under the provisions of the Longshore and Harbor Workers' Compensation Act (LHWCA), as amended, U.S. Code, Title 33, §§ 901 *et seq.*, and is governed by the implementing Regulations found in the Code of Federal Regulations, Title 29,

Part 18, and Title 20, Chapter VI, Subchapter A. The claim was forwarded to the Office of Administrative Law Judges on February 13, 2012 with indication of a June 6, 2000 injury date (OWCP No. 05-109714). In this claim, the Employer[1] disputes the reasonableness and necessity of medical treatment allegedly arising out of the injury.

A formal hearing was held in Newport News, Virginia, on July 19, 2012, at which time the parties were afforded full opportunity to present evidence and argument as provided in the LHWCA and applicable regulations. Present at the hearing were Ralph Rabinowitz, Esq. on behalf of the Claimant and Jonathan Walker, Esq. on behalf of the Employer. The Director did not appear. At the hearing, Administrative Law Judge Exhibits 1 through 4, Joint Exhibit 1, Claimant's Exhibits 1 through 8, and Employer's Exhibits 1 through 3 and 5 through 10 were admitted without objection. (TR[2] at 5-9). Claimant's Exhibit 8 was admitted for the limited purpose of determining entitlement to attorney fees, if warranted. (TR at 7). Claimant's Exhibit 9 was excluded for irrelevance and Employer's Exhibit 4 was withdrawn. (TR at 7-9).

After the hearing, the Employer submitted *curricula vitae* for Drs. Baddar and Davlin, which have been admitted to the record and labeled Employer's Exhibit 11. The Employer also submitted a January 15, 2004 report from Dr. Davlin, which has been admitted to the record and labeled Employer's Exhibit 12. Claimant submitted *curricula vitae* for Drs. Wardell and Pennington, which have been admitted to the record and labeled Claimant's Exhibits 10 and 11, respectively. The post-hearing written briefs filed by the respective counsel for Claimant and the Employer were also considered in this claim.

The findings of fact and conclusions which follow are based upon a complete review of the entire record, in light of argument of the parties, as well as applicable statutory provisions, regulations, and pertinent precedent.

STIPULATIONS

The Claimant and the Employer have stipulated, and this Administrative Law Judge finds, the following as fact (JX 1):

1. The LHWCA, 33 U.S.C. § 901 *et seq.*, as amended, applies to this claim.

2. Claimant injured his right shoulder and right elbow on June 6, 2000.

3. The injury occurred at Newport News Shipyard in a coffer dam.

4. The injury arose out of and in the course of Claimant's employment with the Employer.

[1] "Claimant" is used in this decision vice the proper name of the individual who is the subject of this decision. "Employer" is used vice the name of the respondent employer.
[2] The following exhibit notation applies: JX – joint exhibit; ALJX – Administrative Law Judge exhibit; CX – Claimant's exhibit; EX – Employer's exhibit; TR – transcript of hearing.

5. There was an employer/employee relationship between the Employer and Claimant at the time of the injury.

6. The Employer was timely notified of the injury.

7. The claim was timely filed.

8. The Employer timely filed its notice of controversion.

9. The District Director's Informal Conference was conducted on October 25, 2011.

10. Claimant's average weekly wage at the time of the injury was $595.87.

11. The Employer has paid Claimant compensation as provided in JX 1.

12. Claimant has not returned to his job.

13. Claimant has engaged in alternative employment as a part-time security guard.

ISSUES

The issues remaining to be resolved are (TR at 6-7):

1. Is the right upper extremity surgery recommended by Dr. Wardell based on a medical condition arising out of Claimant's June 6, 2000 work-related injury?

2. Is the right upper extremity surgery reasonable and necessary under Section 907 of the LHWCA?

PARTY POSITIONS

Claimant's Position:

Claimant's counsel requests approval of extensor carpi radialis brevis (ECRB) repair surgery for Claimant's right elbow, as recommended by his treating orthopedist. Counsel argues that the surgery should be approved because it stems from Claimant's June 6, 2000 work-related injury and because it is reasonable and necessary in light of Claimant's pain condition and epicondylitis.

In support of his position that the need for medical treatment arises out of Claimant's June 6, 2000 work-related injury to his right elbow, counsel points out that there is no evidence Claimant complained about the elbow or underwent treatment for it prior to his work-related injury. After the injury, however, the medical evidence shows a record of treatment for right elbow epicondylitis. Counsel contends there is no evidence that Claimant would have suffered from epicondylitis or traumatic arthritis to his right elbow but for his work-related injury.

Counsel also argues that Claimant's epicondylitis and continuing pain render the recommended elbow surgery reasonable and necessary. Citing MRI evidence and treatment notes from Drs. Stiles, Wardell, Ross, and Davlin, counsel asserts that the medical record is replete with findings of epicondylitis. He notes that Claimant's right elbow symptoms and pain worsened over time; physical therapy did not help; and eventually Claimant's doctor took him out of his part-time work as a security guard because the Percocet he used to control the pain made him fall asleep on the job. Counsel argues that the opinions of Drs. Stiles, Wardell, Davlin, and Pennington, supported by Claimant's valid complaints of pain, demonstrate the need for surgery in this case. He contends that the conflicting opinion of Dr. Baddar is undermined by the doctor's refusal to recognize that Claimant suffers from epicondylitis, and is entitled to less weight because Dr. Baddar is not a treating physician.

Employer's Position:

Employer's counsel contends that Claimant is not entitled to compensation for elbow surgery under the LHWCA because the surgery is not reasonable, necessary, or causally related to the injury.

Counsel contends that the opinion of Dr. Baddar should be given controlling weight because it is supported by the medical evidence showing Claimant's history of progressively worsening arthritis and because no other medical opinion has directly contradicted or challenged it. Counsel argues that prior case law supports the rejection of the "treating physician rule," which would automatically accord greater weight to the opinion of Claimant's treating orthopedist than to Dr. Baddar's opinion. In support of this argument, counsel cites various cases in which the treating physician rule was rejected under statutes such as the black lung act, the veterans' benefits act, and the Railroad Retirement Act. Counsel also notes the LHWCA does not provide for a treating physician's opinion to receive more weight than any other medical opinion, and cites an ERISA opinion from the Supreme Court holding that federal courts cannot accord special deference to a treating physician absent a statutory or regulatory mandate.

With respect to the medical evidence, Employer's counsel argues that Claimant's medical history, imaging studies, clinical presentation on examination, and display of symptoms in the absence of activity all support Dr. Baddar's opinion that Claimant suffers from progressive arthritis. Counsel contends that this arthritis is not related to and has not been worsened by Claimant's work-related injury, and that to claim otherwise would be pure speculation. Counsel also asserts that surgery would not help Claimant's arthritis. In support of this argument, counsel contends that Dr. Stiles did not recommend surgery between 2008 to 2011 and cites Dr. Davlin's opinion that Claimant was at maximum medical improvement (MMI) with no disability in 2004.

SUMMARY OF RELEVANT EVIDENCE

Testimony of Claimant, May 14, 2012 (EX 10)

On May 14, 2012, Claimant appeared for deposition and testified Dr. Wardell had taken him out of work on April 17, 2012 because of pain in his right arm and elbow stemming from an earlier work-related elbow and shoulder injury. (EX 10 at 5-7, 21). He indicated the pain was most

acute in the bone around the joint. (EX 10 at 8). Although he could still perform his daily activities, he felt pain "all the time." (EX 10 at 8-10). He explained that when he went to Dr. Wardell and told him about the pain, the doctor suggested elbow surgery. (EX 10 at 13). He could not remember the precise date this happened, but noted it was after he had tried therapy, which did not help him. (EX 10 at 13-14). Claimant testified that Dr. Pennington, another physician who treated him, was also in favor of the suggested surgery. (EX 10 at 21-22).

Claimant testified that before he was taken out of work, he had been working approximately two days per week since 2004 as a nighttime security guard at Lewiston Perdue. (EX 10 at 10-12, 14). He was responsible for manning a station outside the gate, which involved job duties such as logging visitors in by writing down their names, responding to anyone who called from the gate phone seeking entry, and checking the parking lot once per night for suspicious activity. (EX 10 at 11, 15-17).

Claimant acknowledged that his job involved very little physical activity and his elbow did not bother him when he was writing. (EX 10 at 15-16). The reason he was taken out of work, he testified, was because his use of prescription Percocet caused him to frequently fall asleep on his arm and hurt it while at work. (EX 10 at 18-19). He had been taking Percocet since before he saw Dr. Wardell. (EX 10 at 19-20). He tried taking other medications instead, but they did not work. (EX 10 at 18, 20-21).

Testimony of Claimant, July 19, 2012 (TR at 15-23)

Claimant appeared at the formal hearing on July 19, 2012 and testified he began working for the Employer on May 8, 1978. (TR at 15, 22). Before he suffered a work-related injury in 2000,[3] he did not have any problems with his right elbow. (TR at 15). Afterward, he received treatment from Dr. Stiles until the doctor retired. (TR at 15-16). Dr. Stiles operated on Claimant's elbow in April 2001, and discussed Claimant's need for further surgery based on an MRI taken in 2007. (TR at 15-16). Claimant testified that after learning the results of this MRI, "I was telling [Dr. Stiles] about my pain and he said I needed surgery so I decided it won't (sic) hurting that bad to have surgery, to go through that again." (TR at 16). Another MRI was taken by Dr. Stiles in 2010. (TR at 16).

[3] The record shows some confusion as to the date of Claimant's work-related injury. At the hearing, Claimant agreed with his attorney's statement that the injury occurred on May 5, 2000. (TR at 15). Dr. Pennington's notes from her initial consultation with Claimant report the injury date as June 6, 2000. (CX 5). An opinion issued by the Virginia Workers' Compensation Commission in 2003 also reports the injury date as June 6, 2000, but a second opinion issued in 2006 reports an injury date of May 16, 2000. (CX 7). An LS-208 form submitted by the Employer also reports a May 16, 2000 injury date. (EX 1). Dr. Baddar notes an injury date of May 16, 2000 on the first page of his 2011 report, but in the middle of the report he indicates June 6, 2000 as the date Claimant was first seen at the Shipyard Clinic for his work-related injury, and at the end of the report he lists a different injury date of May 6, 2000. (EX 8 at 3, 8, 17). A subsequent report issued by Dr. Baddar lists the injury date as May 5, 2000. (EX 9 at 3). Other medical records, including those from Dr. Stiles, Dr. Davlin, Dr. Ross, Dr. Wardell, and Harbour Rehabilitation, do not mention a specific date of injury. Because the parties to this claim have stipulated Claimant incurred a work-related injury on June 6, 2000 (JX 1) and neither party has alleged that another injury occurred, this opinion will assume that all the testimony and medical evidence submitted in this case refers to Claimant's stipulated June 6, 2000 work-related injury.

Shortly after the 2010 MRI was taken, Dr. Stiles retired and Claimant began seeing Dr. Wardell. (TR at 16). Claimant testified that his elbow pain worsened while he was seeing Dr. Wardell. (TR at 16). After unsuccessfully treating the pain with physical therapy, Dr. Wardell recommended surgery. (TR at 16-17). It was Claimant's impression that Dr. Pennington, his pain management specialist, agreed that he should have surgery. (TR at 18-19). Claimant stated he wanted to have surgery this time because it would help stop his pain. (TR at 17). He testified he had been taking Percocet for the pain for a long time, but it affected his job performance as a weekend security guard because it made him fall asleep and hurt his arm. (TR at 17-18).

On cross-examination, Claimant conceded that Dr. Stiles may have told him in 2009 and 2010 that his symptoms did not warrant surgery. (TR at 19-21). When asked whether Dr. Stiles had told Claimant he had arthritis in his elbow, Claimant replied, "I think he said something about it," but did not seem knowledgeable on the subject of arthritis. (TR at 21). Claimant also testified he was taking Percocet the entire time he was seeing Dr. Stiles and while he was working during that time period. (TR at 21).

On redirect, Claimant noted the pain in his right elbow had worsened after Dr. Stiles' retirement. (TR at 22). At this point, he had discussed surgery with Dr. Wardell. (TR at 22). Claimant also testified he was in pain all the time. (TR at 22).

Medical Treatment Records

The medical records submitted in this claim are summarized below.

1) Documentation of Claimant's right elbow surgery (2001):

3/15/01 (CX 2) In a letter Dr. Thomas M. Stiles, M.D.,[4] Claimant's treating orthopedist, explained that he planned to perform an arthroscopy plus an intra-articular epicondylar release on Claimant's right elbow. He also noted the presence of exostosis and a possible loose body in the elbow joint.

4/5/01 (CX 3, EX 2) An operative report from Mary Immaculate Hospital prepared by Dr. Stiles describes right elbow surgery performed without incident on April 5, 2001. Dr. Stiles carried out an arthroscopy with a synovectomy and an intra-articular lateral epicondylar release. He noted findings of marked synovitis of the elbow joint and the presence of condylar tissue in the joint, although he did not find any loose bodies.

2) Medical report of Dr. Davlin (2004):

1/15/04 (EX 12 at 1-2) Dr. Lance B. Davlin, M.D.,[5] issued a medical report opining that although Claimant suffered from lateral epicondylitis,[6] he had no objective disability arising out of this condition. Dr.

[4] No *curriculum vitae* has been submitted for Dr. Stiles. Judicial notice is taken that Dr. Stiles is Board-certified in Orthopaedic Surgery and worked for Denbigh Orthopaedic & Sports Medicine, P.C. in Newport News during the time he treated Claimant. *See* American Board of Medical Specialties website, http://www.certificationmatters.org/is-your-doctor-board-certified.aspx.

[5] Dr. Davlin's *curriculum vitae* shows he received his medical degree Tulane University School of Medicine in 1986 and is Board-certified in Orthopaedic Surgery with a specialty in Surgery of the Hand. He currently works for Hand Surgery Associates, a division of Orthopaedics Virginia, Inc., and serves as an orthopaedic consultant at various hospitals in the Hampton Roads area. He has written and lectured extensively in the field of orthopedics. (CX 11).

Davlin stated Claimant was right-hand dominant. He described Claimant as a "relatively poor historian" who reported a history of intermittent pain about his right shoulder, elbow, and wrist, accompanied by numbness in his fingers, since the 1980s. He also noted Dr. Stiles had diagnosed Claimant with tendinitis and treated him with right shoulder and elbow arthroscopies that "may have provided some modest benefit." Dr. Davlin then described Claimant's treatment history as he understood it based on treatment notes from Dr. Stiles spanning the time between September 7, 2000 and October 7, 2003. According to Dr. Davlin, the treatment notes revealed that in early 2001, Claimant was felt to have traumatic problems in his right ankle, shoulder, and elbow secondary to a work-related injury and was diagnosed with severe lateral epicondylitis of the right elbow. The treatment record included the operative report from Claimant's April 5, 2001 elbow arthroscopy, but subsequent treatment notes showed Claimant's elbow was still painful, tender, and swollen about the epicondylar region in 2001 and 2002. The treatment notes Dr. Davlin reviewed from 2002 and 2003 revealed Claimant underwent arthroscopic surgery for his right shoulder; was placed on work restrictions; and was treated with Mobic for his various joint complaints.

(EX 12 at 2-4) Dr. Davlin conducted a physical examination of Claimant on January 15, 2004 and reported normal range of motion in the right elbow, with mild right carpal tunnel syndrome in the wrist. He took an x-ray that showed moderate degenerative changes in the elbow, including osteophyte formation at the olecranon and narrowing of the elbow joint. Dr. Davlin also noted Claimant's treatment record contained a right elbow x-ray from June 3, 2003 that was normal except for a small traction spur at the olecranon and a right elbow x-ray from June 6, 2000 showing a degenerative spur at the olecranon, no fracture-dislocations, and no significant joint effusion.

(EX 12 at 4-5) Based on his observations and his review of Claimant's medical records, Dr. Davlin diagnosed Claimant with mild right carpal tunnel syndrome and noted "it appears that he did have lateral epicondylitis" of the right elbow. Dr. Davlin explained to the patient that epicondylitis was a frustrating problem with no simple solution, and that treatment options could include splints, anti-inflammatories, steroid injections, and surgical intervention. He opined that Claimant had reached MMI with respect to the elbow and had no disability from an objective standpoint. Specifically, he commented there was no way to objectify Claimant's chronic right elbow pain in terms of a rating. He noted his belief that a significant portion of the elbow pain resulted from underlying degenerative changes, which might cause articular stiffness and pain in the future, and recommended traditional treatment for osteoarthritis. With respect to Claimant's functional capabilities, Dr. Davlin opined he could be gainfully employed, but should be restricted from climbing ladders or performing repetitive elbow flexion.

3) Orthopedic treatment records from Dr. Stiles (2007–2010):

10/17/07 (CX 2) A progress note from Dr. Stiles reveals he examined Claimant on this date in his office at Denbigh Orthopaedic & Sports Medicine in Newport News, Virginia. He observed mild tenderness over the lateral epicondylar area of Claimant's elbow with some crepitation with motion, but no swelling or redness. He reported that an MRI showed lateral epicondylitis with tearing of the lateral collateral ligament. He commented, "It is my opinion this represents old scarring and not a new tear. He has had surgery of this elbow in the past. This is a continuation of his epicondylitis. The possibility of injections or repeat surgery was discussed. [Claimant] does not think he is having sufficient symptoms to warrant that degree of treatment."

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[6] Judicial notice is taken that lateral epicondylitis, or "tennis elbow," is tendinitis of the tendon that attaches certain forearm muscles to the humerus. The muscles attach to the bone at the lateral epicondyle, which is the bony protuberance on the outside of the elbow. *See* Waldemar Karwowski & William S. Marras, eds., *The Occupational Ergonomics Handbook*, 813-14 (1999).

5/6/08 (EX 3) A progress note from Dr. Stiles reveals Claimant saw him on this date for a follow-up on his right shoulder and arm pain. Dr. Stiles noted the patient's history of rotator cuff problems and epicondylitis, both work-related, and tenderness in the lateral epicondylar area of the right elbow. He advised the patient to continue using Celebrex, which seemed to be helping, and to see a pain management physician if he needed more Percocet.

10/9/08 (CX 2) A progress note from Dr. Stiles reveals Claimant presented on this date with complaints of pain in his right elbow and shoulder. Examination of the elbow revealed tenderness in the lateral epicondylar area and over the olecranon, with no redness or marked swelling, and pain with gripping and extreme flexion. X-rays showed a fragmented olecranon spur and some arthritic changes, but no evidence of loose bodies or destructive lesions in the elbow and no significant changes since 2005. Dr. Stiles prescribed Percocet, referred Claimant to a pain management doctor, and advised him he would need an MRI if his symptoms worsened.

4/21/09 (EX 3) A progress note from Dr. Stiles reveals Claimant was seen on this date for a follow-up on his right shoulder. Dr. Stiles noted Claimant was able to work as a security guard for Perdue despite his problems with the right upper extremity, and advised him to continue rehabilitative therapy at the YMCA.

7/16/09 (CX 2) A progress note from Dr. Stiles reveals he saw Claimant on this date for a follow-up on pain in his right elbow and shoulder. Physical examination of the elbow again showed tenderness over the lateral epicondyle with no marked swelling or redness, and x-rays showed mild calcification in the same area. Claimant's right shoulder showed signs of impingement syndrome.

8/11/09 (EX 3) A progress note from Dr. Stiles reveals Claimant was seen on this date for a follow-up on his right shoulder. Dr. Stiles advised Claimant surgery was not needed.

9/23/09 (CX 2) A progress note from Dr. Stiles reveals he saw Claimant on this date for increased pain in both his shoulder and elbow. The pain in the elbow was noted to be worse than in the shoulder, and the patient also reported swelling in the elbow. Dr. Stiles noted Claimant had not been doing anything different or unusual and had not suffered a new injury. Physical examination of the elbow revealed swelling over the lateral epicondyle area, tenderness at the common extensor origin and over the olecranon, but no marked swelling or redness. Claimant felt pain upon forced extension and passive flexion of his wrist when his elbow was in extension. X-rays showed calcific deposit in the extensor origin and a fracture and spur over the olecranon. Claimant was advised to return to taking Celebrex.

12/7/09 (EX 3) A progress note from Dr. Stiles reveals he saw Claimant on this date for follow-up on his right elbow. Claimant continued to complain of pain. Findings on physical examination, x-ray, and MRI were substantially similar to prior findings. Dr. Stiles reported that in his opinion, further surgery would not help Claimant much, and noted Claimant continued to take pain medication and to undergo pain management for his elbow.

1/18/10 (CX 4) A report of a right elbow MRI taken on this date indicated mild to moderate lateral epicondylitis with small areas of partial interstitial tearing and very little change since October 2007. The MRI also revealed scar tissue in the lateral common extensor origin and in the lateral head of the triceps, ulnar nerve swelling, and swelling around the medial epicondyle.

1/26/10 (EX 3) A progress note from Dr. Stiles reveals he saw Claimant on this date for another follow-up on his continuing complaints of chronic right elbow pain. Dr. Stiles discussed the MRI findings with Claimant and reiterated that he did not believe the patient's symptoms were sufficient to warrant surgical intervention.

3/16/10 (EX 3) A progress note from Dr. Stiles reveals he saw Claimant on this date for follow-up on his elbow. Claimant reported the exercise program he was participating in at his local YMCA was "definitely improving his elbow" and his pain had decreased. However, Dr. Stiles still noted

tenderness over the medial and lateral epicondyle and the olecranon. He prescribed Percocet and Celebrex and advised Claimant to continue the exercise program.

4/12/10 (EX 5) A progress note from Dr. Stiles reveals he saw Claimant on this date for follow-up on his right shoulder. During this office visit, Claimant also reported suffering from continuing problems with his elbow.

4/27/10 (EX 5) A progress note from Dr. Stiles reveals he saw Claimant on this date for follow-up on his right elbow. Claimant again reported the exercise program at the YMCA was helping him, but he still displayed tenderness in the elbow, limited range of motion on extension, and pain with stress to his common extensors. Dr. Stiles advised Claimant to continue his exercise regimen and to find a new doctor, as Dr. Stiles planned to retire soon.

6/15/10 (CX 2) A progress note from Dr. Stiles reveals Claimant was seen on this date for evaluation of his right shoulder and elbow. Dr. Stiles' observations were substantially similar to his prior findings. He commented that Claimant was in a pain management program and an active exercise program.

4) Pain management records from Drs. Ross and Pennington (2009–2012):

10/19/09 (EX 3) In a treatment report dated October 19, 2009, Dr. Mark A. Ross, M.D.,[7] a pain management and rehabilitation specialist, noted he had last seen Claimant in July and Claimant was still complaining of pain in his right shoulder and elbow. Physical examination revealed tenderness to palpation of the elbow, particularly over the right lateral epicondylar region, and pain in this region upon extension of the wrist against resistance. Dr. Ross reported Claimant was taking approximately 20 Percocet tablets per month and had not experienced any side effects except occasional dizziness. He refilled the prescription and commented, "Today's examination is somewhat suggestive of a lateral epicondylitis on the right. I suggested [Claimant] point that out to Dr. Stiles. He may be a candidate for steroid injection in that region."

7-8/10 (CX 5) Documentation from Dr. Tracey O. Pennington, M.D.[8] of the Sports Medicine and Orthopaedic Center in Suffolk, Virginia reveals Claimant registered for pain management treatment there and signed a Pain Management Agreement on July 25, 2010. Dr. Pennington's notes from the initial consultation on August 19, 2010 indicate Claimant was referred to her by Dr. Ross. Claimant presented complaining of residual pain in his right shoulder and elbow stemming from a June 6, 2000 work-related injury for which he had undergone arthroscopic surgery. Dr. Pennington noted the patient described the pain as chronic, daily, and aching and throbbing in nature, with an average severity score of 2 to 5 out of 10. She also noted the patient's history of treatment for gout, hypertension, diabetes mellitus, and benign prostatic hypertrophy. On physical examination, the doctor reported mild swelling of the right elbow and pain with resistance. She concluded that she would continue Claimant on his previous regimen of Percocet for his pain.

9/10 – 3/11 (CX 5) Progress notes from Dr. Pennington show she saw Claimant three times between September 2010 and March 2011. On September 20, 2010, she noted mild swelling in the right lateral elbow and tenderness over the epicondylar prominence. She stated Claimant's chronic pain syndrome was "well-managed with Percocet therapy, averaging #20 tablets per 30-day intervals," and refilled his prescription for Percocet. On December 20, 2010, she again noted tenderness over

[7] No *curriculum vitae* has been provided for Dr. Ross. Judicial notice is taken that he is Board-certified in Physical Medicine and Rehabilitation. *See* American Board of Medical Specialties website, http://www.certificationmatters.org/is-your-doctor-board-certified.aspx.

[8] Dr. Pennington's *curriculum vitae* shows she received her medical degree from Tulane University School of Medicine in 1995. She is Board-Certified in Physical Medicine and Rehabilitation with experience practicing medicine since 2001. She currently serves as physician and part owner of the Pain Management & Orthopedic Center in Virginia Beach, Virginia. (CX 11).

the epicondylar prominence in Claimant's right elbow but noted his pain was well-managed. She issued a Percocet refill and a prescription for Piroxicam to assist with pain management. On March 14, 2011, Dr. Pennington saw Claimant again and reported his complaints of an aching pain in his right elbow and shoulder with a 4 to 5 out of 10 in severity, exacerbated by lifting. She also reported Claimant had a history of osteoarthritis. She noted that medication, physical therapy, local application of heat, and local injections had helped his pain. She refilled his Percocet prescription for treatment of "chronic musculoskeletal pain syndrome with permanent disability."

5-12/11 (CX 5, EX 6) Dr. Pennington saw Claimant seven times between May and December 2011 to refill his Percocet prescription. In treatment notes dated May 25, 2011, she reported Claimant was tolerating the activities of daily living well, without complaints of night pain or wrist pain, and was not having side effects from his pain medications. However, she noted swelling in his medial and lateral elbow. Dr. Pennington's progress notes from Claimant's office visit on June 23, 2011 were the same, except that she reported a slight increase in Claimant's elbow pain associated with performance of everyday activities over the past few weeks and commented, "The patient plans to discuss potential additional surgical treatment options with his orthopedic surgeon." She also noted his current medications included low-strength adult aspirin, 800 mg Ibuprofen three times per day, Percocet 5-325 as needed, and Percocet 7.5-325 twice per day. Office visit notes from August 2, September 1 and 29, October 26, and December 19, 2011 were substantially the same.

1-5/12 (CX 5, EX 6) Dr. Pennington saw Claimant four times between January and May 2012 to refill his Percocet prescription. On January 17, 2012, Dr. Pennington examined Claimant and reported his pain had decreased "from a 5/10 to a 1/10 only medication administration." She again reported Claimant was tolerating the activities of daily living well, without complaints of night pain or wrist pain, and was not having side effects from his pain medications. However, she also noted he still had swelling in his right elbow. Progress notes from February 16, 2012 were substantially the same. Progress notes from April 16, 2012 were substantially the same except that Dr. Pennington reported Claimant had been taken out of work pending reevaluation by Dr. Wardell on April 25. Progress notes from May 15, 2012 were substantially the same.

5) Orthopedic treatment records from Dr. Wardell (2011–2012):

11/10 – 3/11 (CX 1) Records submitted in this case show Claimant selected Dr. Arthur W. Wardell, M.D.,[9] to serve as his treating orthopedist after Dr. Stiles retired. A Choice of Physician Authorization was signed by Claimant on November 12, 2010 and by the Employer on January 31, 2011. A workers' compensation authorization was signed by the Employer on March 3, 2011 so Claimant could move forward with his treatment.

On March 10, 2011, Dr. Wardell's office completed an eight-page Treatment History Outline that summarized Claimant's orthopedic treatment as Dr. Wardell's office understood it between September 7, 2000 and June 15, 2010. The outline noted that Claimant's right shoulder and elbow were evaluated on September 7, 2000 after he banged his elbow several times at work, and he was given an injection in the elbow and two weeks of physical therapy. Despite medication and work restrictions, Claimant did not show improvement over the next few months, leading his doctor to perform the April 5, 2001 right elbow arthroscopy discussed above. Claimant was also placed in physical therapy and restricted to light duty at work. However, he continued to have problems with the elbow. On August 9, 2001, his doctor noted permanent loss of extension in the right elbow and gave Claimant an injection in the elbow. In late 2001, the doctor noted physical therapy was not helping. On January 16, 2002, it was noted x-rays showed only 2 mm of cartilaginous surface. In 2003, an x-ray showed degenerative changes and bone spurs in the elbow.

[9] Dr. Wardell's *curriculum vitae* shows he received his medical degree from Cornell University in 1975. He is Board-certified in Orthopaedic Surgery with experience practicing this field of medicine since 1980. He currently works at Wardell Orthopaedics in Portsmouth, Virginia. (CX 10).

In addition to the elbow problems, the Treatment History Outline indicates Claimant also had problems with his right shoulder and hand. In 2004, Claimant was placed on permanent restrictions relative to his upper extremities. On January 17, 2005, his doctor gave him a 24% impairment rating of the entire right upper extremity as a result of injuries incurred at the shipyard.

Meanwhile, Claimant continued to have problems with his right elbow. An x-ray taken May 19, 2005 showed degenerative changes and a bone spur in the elbow. His doctor recommended an MRI of the elbow in October 2007. Progress notes from Claimant's subsequent course of treatment with Dr. Stiles were summarized in the Treatment History Outline from Dr. Wardell's office consistent with the evidence of record.

3/25/11 (CX 1, EX 7) In his notes from Claimant's initial office visit on March 25, 2011, Dr. Wardell briefly summarized the patient's history of treatment for his work-related right elbow and shoulder injuries, and explained he had been referred by Dr. Stiles. He noted that Claimant complained the pain and swelling in his right elbow and shoulder had recently increased without any new injury. Physical examination of the elbow revealed full range of motion, lateral epicondyle tenderness, and pain upon isometric wrist extension. An x-ray showed calcification and prominence over the lateral epicondyle, with radiocapitellar spurring and an olecranon spur. Dr. Wardell diagnosed right lateral epicondylitis status post lateral release. He noted the patient would start a trial of manual therapy and get an ultrasound of the shoulder and elbow. He wrote a prescription for 12 physical therapy sessions, which were approved by the Employer on March 29, 2011.

3/30/11 (CX 1, EX 7) A limited ultrasound study of the right elbow showed some cortical irregularity about the lateral epicondyle.

4/7/11 (CX 1, EX 7) Notes from an office visit with Dr. Wardell on this date reveal that physical therapy was not helping Claimant's pain in his right elbow and shoulder at this time. Physical examination of the right elbow revealed lateral joint line tenderness. Dr. Wardell noted the patient was not a candidate for steroid injections due to his uncontrolled diabetes, but would continue physical therapy.

5/11 – 2/12 (CX 1, EX 7) On May 5, 2011, Dr. Wardell saw Claimant at his office and noted physical therapy still had not helped, as the patient was still experiencing pain, aching, and swelling in his right arm and elbow. Physical examination revealed lateral epicondyle tenderness in the patient's elbow. Dr. Wardell commented at this point that he planned to seek authorization for a right elbow arthroscopy. He saw Claimant ten more times between June 2, 2011 and February 27, 2012, and Claimant's symptoms of pain and swelling and physical examination results remained substantially the same. In June, Dr. Wardell commented that Claimant had good range of motion in his elbow. He reported a 20º-90º range of motion in the elbow June 29, July 27, and August 24, 2011 and a 10º-90º range of motion on September 21, 2011. After November, he repeatedly noted a 10º flexion contracture in the elbow.

Based on Claimant's symptoms during this time period, Dr. Wardell recommended treatment with physical therapy and right elbow arthroscopic surgery. On June 29, 2011, he prescribed 12 more physical therapy sessions and commented that he was now recommending an extensor carpi radialis brevis (ECRB) repair surgery instead of an arthroscopy for Claimant's elbow. The Employer declined to authorize either course of treatment. Dr. Wardell again submitted a request for approval of ECRB surgery on January 4, 2012, and the Employer again denied the request on January 25, 2012. A further request for physical therapy was also rejected on April 24, 2012. Correspondence sent to Dr. Wardell from the Employer's workers' compensation division indicated the denials were based on a medical opinion issued by Dr. Adrian Baddar.

Dr. Wardell took Claimant out of work on April 17, 2012. Work restriction forms submitted with the medical records reveal that Claimant had not yet been released for work as of June 22, 2012.

6) Physical therapy records from Harbour Rehabilitation (2011):

3-5/11 (CX 6) Documentation from Harbour Rehabilitation, a division of Wardell Orthopaedics, P.C., reveals Claimant participated in twelve physical therapy sessions between March 31, 2011 and May 10, 2011 for his right shoulder and elbow. Therapy undergone by Claimant included laser stimulation, hot pack application, and manual therapy incorporating the Graston technique and myofascial release. However, progress notes from the therapy sessions show that Claimant's condition did not improve significantly over the course of treatment. In the note from the final session on May 10, 2011, the physical therapist reported that Claimant's symptoms had not changed and he was experiencing constant discomfort in his right elbow.

7) Medical reports of Dr. Baddar (2011–2012):

8/25/11 (EX 8) Dr. Adrian T. Baddar, M.D.,[10] an orthopedist, examined Claimant on July 19, 2011 and issued a report on August 25, 2011 based on his observations and review of medical records. In his report, he relayed a detailed summary of Claimant's medical history since he incurred a work-related injury in May or June 2000. Dr. Baddar noted that after the injury Claimant had been treated for right elbow epicondylitis at the Shipyard Clinic. (EX 8 at 8). Here, Claimant reported past problems with his right shoulder and chronic problems with his right hand, and x-rays were taken showing mild degenerative joint disease of the elbow. (EX 8 at 8). After several months of treatment, the Clinic referred Claimant to Dr. Stiles on August 31, 2000. (EX 8 at 8). Claimant was seen by Dr. Stiles on September 7, 2000 after banging his elbow again, at which time he reported a history of arthritis in his shoulder. (EX 8 at 3). He had lateral epicondyle tenderness and pain with certain motions, and x-rays showed calcification in the soft tissue around the elbow and some narrowing of the joint surface but no evidence of marked degenerative process and no fractures or dislocation. (EX 8 at 3-4). He was given an injection in the lateral epicondyle area that afforded complete relief at that time. (EX 8 at 4).

However, the medical records Dr. Baddar reviewed showed that Claimant's elbow problems continued. His epicondylitis recurred in November 2000, at which time x-rays were noted to show exostosis and a bone spur, and his doctor recommended surgery. (EX 8 at 4). Notes from the Shipyard Clinic revealed Claimant was out of work for his elbow around this time and was diagnosed with gouty arthritis in his right lower extremity. (EX 8 at 8). In 2001, Claimant was thought to have permanent disability relating to his elbow and was put into an active therapy program that did not cure his symptoms. (EX 8 at 4). An x-ray taken in January 2002 showed post-traumatic arthritis with only 2 mm cartilage remaining in the elbow,[11] and an x-ray taken in May 2002 showed degenerative arthritis in the elbow. (EX 8 at 5). Treatment notes from this time period indicated Claimant displayed symptoms including elbow pain, lateral epicondyle tenderness, loss of extension, and crepitation. (EX 8 at 5-6). In March 2004 Claimant's doctor

[10] Dr. Baddar's *curriculum vitae* shows received his medical degree from University of Virginia in 1997 and currently works at Hampton Roads Orthopaedics & Sports Medicine in Newport News. (EX 11). Judicial notice is taken that he is Board-certified in Orthopaedic Surgery. *See* American Board of Medical Specialties website, http://www.certificationmatters. org/is-your-doctor-board-certified.aspx.

[11] Dr. Baddar's report mentions in two different places that an x-ray read by Dr. Stiles showed 2 mm of cartilage in Claimant's elbow. First, the report describes a January 16, 2002 note of an x-ray showing post-traumatic arthritis with narrowing of the cartilaginous base to just 2 mm in the elbow joint but no loose bodies or destructive lesions. (EX 8 at 5). Later, the report describes a January 27, 2000 note of an x-ray showing degenerative arthritis and a decrease to 2 mm of cartilaginous space in the elbow, along with exostosis and spurring. (EX 8 at 8). Dr. Baddar's notation of the January 2000 x-ray appears to be a typo, for several reasons. First, in the context of Dr. Baddar's report, it is not listed in chronological order. Second, the report clearly indicates Dr. Baddar did not review any treatment notes from Dr. Stiles predating September 7, 2000. (EX 8 at 14). In fact, according to the report, Claimant was not even referred to Dr. Stiles until August 2000. (EX 8 at 8). Finally, based on Dr. Baddar's discrepancies in reporting Claimant's injury date, discussed above in footnote 3, it seems that he failed to carefully review the dates he listed in his report.

determined he was permanently disabled from any type of gainful employment requiring the use of his upper extremities. (EX 8 at 7). A functional capacity evaluation in May 2005 showed Claimant was able to work in a light physical demand classification with some skills in the medium demand classification, and he was given a 2% impairment rating of the elbow and taken out of his job as a chipper at the shipyard. (EX 8 at 13).

From 2005 to June 2011 (when Dr. Baddar's treatment history summary ends), Claimant's elbow continued to be symptomatic even though he was treated with an exercise program, anti-inflammatories, pain medications, and cortisone injections. (EX 8 at 8-13). Dr. Baddar noted that Claimant was diagnosed with traumatic arthritis of the elbow on October 3, 2007. (EX 8 at 9). He also reported that an MRI from October 2007 showed lateral epicondylitis with proximal tearing of the lateral collateral ligament due to the previous elbow surgery. (EX 8 at 9-10,14). Claimant's pain symptoms and imaging results remained substantially similar over time, so Dr. Stiles referred Claimant to pain management specialists Dr. Pennington and Dr. Ross, who noted in October 2009 that Claimant showed symptoms of lateral epicondylitis and recommended a cortisone injection. (EX 8 at 11). A subsequent injection did not help Claimant's pain. (EX 8 at 11). Dr. Baddar reviewed documentation of Claimant's further course of treatment from October 2007 forward as submitted into evidence.

After concluding his detailed review of Claimant's treatment history, Dr. Baddar noted his observations on examination of the patient. (EX 8 at 15). He reported Claimant's complaints of elbow pain along the lateral side going into his proximal forearm, and difficulty straightening and moving the elbow. The patient said the pain could occur at any time, usually bothered him first thing in the morning, and occasionally woke him up at night, but did not cause difficulty at work. The patient reported no improvement with cortisone injections and no lasting improvement from physical therapy. Physical examination revealed tenderness along the lateral aspect, with some tenderness occurring over the epicondyle, but most occurring towards the brachioradialis. The ulnar nerve also displayed tenderness. The patient had lost a few degrees of extension, but Dr. Baddar noted he had good range of motion in his arm. Supination, pronation, and resisted wrist extension and flexion elicited weakness but no pain in the patient.

Based on his examination of the patient and review of the pertinent treatment records, Dr. Baddar declined to recommend surgery or physical therapy for Claimant's right elbow. (EX 8 at 16-17). He agreed with Dr. Davlin's 2004 report concluding the patient had reached maximum medical improvement (MMI) for his work-related elbow injury. (EX 8 at 17). Dr. Baddar noted that he had found no evidence of epicondylitis, and that changes seen in the MRI results were consistent with Claimant's prior surgery, as indicated by Dr. Stiles. (EX 8 at 16). He reported significant arthritic changes in Claimant's elbow, noting these changes predated Claimant's work-related injury because they were present on his earliest x-rays. (EX 8 at 16). In support of the diagnosis of arthritis, Dr. Baddar explained that the patient's x-ray results, loss of motion, and symptoms of pain at night and stiffness in the morning were more consistent with ongoing arthritis changes than epicondylitis. (EX 8 at 16). He could not pinpoint the cause of the patient's arthritis but suggested the condition might stem from genetic predisposition, overuse, underlying gout, or underlying rheumatoid process. (EX 8 at 17).

In light of his findings, Dr. Baddar recommended continued treatment of Claimant's symptoms with anti-inflammatories and activity modification to accommodate the arthritic elbow. (EX 8 at 16). He indicated that steroid injections might help combat pain flare-ups, but noted that injections and physical therapy had not helped Claimant in the past. (EX 8 at 16). Dr. Baddar did not support Dr. Wardell's recommendation of a right elbow arthroscopy. (EX 8 at 16). He explained he did not think such surgery was warranted because he saw no evidence of epicondylitis and because prior arthroscopic surgery had only minimally benefitted Claimant, since his underlying arthritis was the main cause of his problems. (EX 8 at 16). Dr. Baddar also noted there was no reason to expect surgery would benefit Claimant at this time because Claimant had already reached MMI for his elbow injury and was not currently suffering from any loose

bodies or mechanical block to motion in his elbow except for loss of motion resulting from arthritic spur formation. (EX 8 at 16-17).

5/25/12 After Dr. Wardell changed his recommendation of right elbow arthroscopy to recommend ECRB repair surgery instead, the Employer requested further advice from Dr. Baddar. Dr. Baddar issued a brief report reiterating that based on his examination of Claimant and review of the pertinent medical records, he did not believe Claimant had lateral epicondylitis at this time but rather believed his problems were caused by underlying arthritis. (EX 9 at 3). He reported there were no clinical findings supporting the need for ECRB surgery, and opined such surgery would not change Claimant's underlying arthritic condition. (EX 9 at 3). He stated Claimant had long since reached MMI for his occupational injury, and noted the injury did not prevent Claimant from performing light duty work – rather, Claimant's issues at work arose from his Percocet use. (EX 9 at 3). Dr. Baddar opined that long term Percocet use was generally inadvisable and was unwarranted in this specific case because there was no reasonable medical evidence to support using a narcotic to treat the patient's chronic arthritic changes. (EX 9 at 4).

Opinions decided under the Virginia Workers' Compensation Act

1) September 5, 2003 opinion of the Virginia Workers' Compensation Commission (*Stanley E. Johnson v. Newport News Shipbuilding & Dry Dock Co.*, File No. 201-90-12) (CX 7)

In a decision addressing Claimant's work-related right elbow and right shoulder injuries incurred on June 6, 2000, the Virginia Workers' Compensation Commission (VWCC) noted that they had issued a prior order awarding Claimant compensation benefits and payment of reasonable and necessary medical expenses. The prior order had been entered for record purposes only because Claimant was already receiving longshore benefits under the LHWCA.

At issue in the September 5 case was whether Claimant had failed to cooperate with vocational rehabilitation such that his outstanding award of benefits should be terminated or suspended. The VWCC noted that a worker has no obligation to work with vocational rehabilitation until medically released to work. Claimant was taken out of work at the shipyard in early 2003 and was not released to light duty until April 16 of that year, so the VWCC found that his failure to cooperate with vocal rehabilitation in March, before he was released for work, was not unreasonable. The VWCC also found that the Employer's vocational specialist did not clearly request or require Claimant's participation in a vocational assessment. Accordingly, the VWCC found Claimant had not unreasonably failed to cooperate with vocational rehabilitation and ordered the Employer to resume payment of temporary total disability benefits.

2) March 7, 2006 opinion of the Virginia Workers' Compensation Commission (*Stanley E. Johnson v. Newport News Shipbuilding & Dry Dock Co.*, File No. 201-90-12) (CX 7)

In another decision concerning the same injuries as before, the VWCC addressed whether Claimant had improperly refused selective employment such that his award of benefits should be terminated. Claimant had been offered a job conducting surveys by phone and recording the results. He attempted to perform the job, but soon stopped because the writing bothered his arm and because he was not adept at the work due to his poor diction and limited education. Accordingly, the VWCC found that the work offered to Claimant was not suitable selective employment and ordered the Employer to resume payment of benefits. The VWCC also found, based on medical evidence, that Claimant had suffered a 15% loss of use of his right arm (rather

than the 24% suggested by Claimant and Dr. Stiles) and had not established that his left shoulder impairment was a compensable consequence of his workplace injury.

Notice of Final Payment or Suspension of Compensation Payments (EX 1)

An LS-208 form submitted in this claim shows that currently, the Employer is voluntarily paying Claimant permanent partial disability benefits under the LHWCA. The Employer currently has a credit from payments made under the Virginia Workers' Compensation Act.

DISCUSSION

At issue in this case is whether the right elbow surgery recommended by Claimant's doctor is reasonable, necessary, and related to Claimant's workplace injury of June 6, 2000 such that the Employer should be compelled to pay for it under the Longshore and Harbor Workers' Compensation Act (LHWCA), as amended, U.S. Code, Title 33, §§ 901 *et seq*. The original injury occurred at Newport News Shipbuilding, the shipyard operated by the Employer in the Port of Hampton Roads in Virginia. Accordingly, the precedent of the U.S. Court of Appeals for the Fourth Circuit applies.

I. <u>Claimant's current right elbow injury status and associated pain are related to his June 6, 2000 workplace injury.</u>

Under the LHWCA, a claimant can receive compensation for medical expenses only if the condition necessitating the expenses is work-related. Section 920(a) of the LHWCA provides a claimant with a presumption that his condition is causally related to his employment if he makes a prima facie showing that he sustained a harm or pain and that employment conditions existed or a work accident occurred which could have caused, aggravated, or accelerated the harm or pain. *Kelaita v. Triple A Machine Shop*, 13 BRBS 326 (1981); *see also 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). The § 920(a) presumption can be invoked to relate a degenerative condition to a work injury. *Uglesich v. Stevedoring Services of America*, 24 BRBS 180 (1991). Once the presumption is invoked, the burden shifts to the employer to put forth substantial evidence of the lack of a causal nexus between the claimant's work and his condition. *See Richardson v. Newport News Shipbuilding & Dry Dock Co.*, 39 BRBS 74, 77 (2005), *aff'd mem. sub nom. Newport News Shipbuilding & Dry Dock Co. v. Director, OWCP*, 245 Fed. Appx. 249 (4th Cir. 2007); *Universal Maritime Corp. v. Moore*, 126 F.3d 256, 262, 31 BRBS 119, 123 (CRT) (4th Cir. 1997); *see also* 33 U.S.C. § 920 (providing that the presumption applies only "in the absence of substantial evidence to the contrary").

In this case, the parties have stipulated that Claimant sustained a work-related injury to his right elbow on June 6, 2000. (JX 1). Thus, Claimant has established that a work accident occurred which could have caused, aggravated, or accelerated his elbow problems.

At the formal hearing, Claimant testified he had never experienced any problems with his elbow prior to the work-related injury. (TR at 15). The medical evidence shows that from the time of

the injury to the present he has suffered intermittent pain, tenderness, and loss of motion in his right elbow. In 2001, he underwent arthroscopic surgery on the elbow with a lateral epicondylar release (cutting a tendon to alleviate tension on the joint) to address problems arising from the work-related injury. (CX 3, EX 2). However, the record shows his elbow problems persisted. In May 2008, Dr. Stiles reported that Claimant's right elbow showed a continuation of his work-related lateral epicondylitis. (EX 3). At least three doctors have found evidence of right lateral epicondylitis in the elbow since then: Dr. Ross noted findings suggestive of epicondylitis in October 2009 (EX 3); Dr. Stiles reported MRI findings consistent with epicondylitis as late as January 2010 (CX 4); and Dr. Wardell diagnosed lateral epicondylitis status post epicondylar release the first time he examined Claimant in March 2011, and has not reported significant improvement in the patient's condition since then (CX 1, EX 7). Drs. Stiles, Ross, and Wardell are all credible, Board-certified doctors who relied on clinical imaging data and physical examination of the patient to reach their respective opinions. Based on all the foregoing, Claimant has established that he developed a right elbow injury and associated pain following his June 6, 2000 work accident.

Because Claimant has made a prima facie showing that he suffered a harm or associated pain and that a work accident occurred that could have caused or aggravated the harm/pain, he is entitled to the benefit of the § 920(a) presumption that his elbow injury and associated pain are causally related to his June 6, 2000 work-related injury.

As noted above, once the § 920(a) presumption is invoked, the Employer bears the burden of putting forth substantial evidence that there is no causal nexus between Claimant's work and his elbow condition. The Employer in this case has submitted medical evidence from Dr. Baddar opining that Claimant does not suffer from lateral epicondylitis; rather, Dr. Baddar believes Claimant's elbow symptoms result from arthritic changes predating his work-related injury. (EX 8 at 16, EX 9 at 3). Similarly, in 2004, just a few years after the workplace injury, Dr. Davlin also found that Claimant's elbow problems were caused in large part by degenerative arthritis unrelated to his occupational injury. (EX 12 at 4-5). Drs. Baddar and Davlin are credible, Board-certified physicians whose medical reports are adequately documented and reasoned. Their conclusion that Claimant suffers from arthritis is supported by his reported symptoms and by the x-ray and MRI results showing degenerative changes and formation of bone spurs in his elbow.

However, I find that on balance, their opinions do not provide substantial evidence rebutting the presence of right lateral epicondylitis arising out of Claimant's occupational injury. As Claimant's counsel has argued, the medical record is replete with findings of epicondylitis. In fact, even Dr. Davlin agreed that Claimant had this condition. (EX 12 at 4). Dr. Baddar's report, by itself, is not enough to overcome the consistent findings of epicondylitis; although he makes a persuasive case that Claimant suffers from arthritis, he does not offer persuasive reasons to discredit the reasoned and documented diagnoses of epicondylitis made by the other physicians. The Employer has not submitted evidence identifying any factor other than Claimant's June 6, 2000 work-related injury that could have caused him to develop epicondylitis, nor has the Employer put on any evidence that Claimant suffered from this condition prior to his work-related injury. Accordingly, the Respondent Employer has failed to I find that the § 920(a) presumption has not been rebutted.

Claimant has established by operation of the § 920(a) presumption that he suffers from a harm and associated pain which are related to his June 6, 2000 occupational injury. The right elbow ECRB repair surgery recommended by Claimant's treating physician stems from this harm and associated pain. Therefore, because the recommended surgery is related to Claimant's occupational injury, Claimant is entitled to compensation for the surgery if it is found to be reasonable and necessary.

II. Claimant has not established that the right elbow ECRB repair surgery recommended by his treating physician is reasonable and necessary.

Under § 907 of the LHWCA an employer is required to furnish to the employee "such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the [work-related] injury or the process of recovery may require." In order for medical expenses to be assessed against the employer, the medical expense must be both reasonable and necessary for addressing the work-related injury. *See Ballesteros v. Willamette Western Corp*., 20 BRBS 184 (1988); *Pernell v. Capitol Hill Masonry*, 11 BRBS 532 (1979). The claimant has the burden to establish that the medical treatment provided for a work-related injury is both reasonable and necessary. *Weikert v Universal Marine Service Corp*., 36 BRBS 38 (2002); *Newport News Shipbuilding & Dry Dock Co. v. Loxley*, 934 F.2d 511 (4th Cir. 1991), *cert. denied* 112 S. Ct. 1941 (1992); *Maryland Shipbuilding & Drydock Co. v. Jenkins*, 594 F.2d 404 (4th Cir. 1979), *rev'g* 6 BRBS 550 (1977). Functionality, cost, professional accreditations, success rates, and experience of providers are factors that may be considered on the issue of reasonableness of competing viable courses of medical treatment. *Green v. Ceres Marine Terminals, Inc*., 43 BRBS 173 (2010), *rev'd on other grounds*, 656 F.3d 235 (4th Cir. 2011); *Monta v. Navy Exchange Service Command*, 39 BRBS 104 (2005); *Amos v. Director, OWCP*, 153 F.3d 1051 (9th Cir. 1998), *amended*, 164 F.3d 480 (9th Cir. 1999), *cert. denied*, 528 U.S. 809 (1999); *Schoen v. U.S. Chamber of Commerce*, 30 BRBS 112 (1996).

A claimant establishes a prima facie case for compensable § 907 benefits when a qualified physician reports that the medical treatment was/is necessary for the work-related injury. *Monta v. Navy Exchange Service Command*, 39 BRBS 104 (2005); *Turner v. Chesapeake & Potomac Telephone Co*., 16 BRBS 225 (1984); *Barbour v. Woodward & Lothrop, Inc.*, 16 BRBS 300 (1984). A claimant need not file a separate claim for medical benefits, and if a prima facie case for medical treatment is established, the employer must present substantial evidence in opposition to rebut the reasonableness or necessity of the medical treatment or demonstrate that the medical expense is the result of a subsequent intervening cause unrelated to the work-related injury. *See Salusky v. Army Air Force Exchange Service*, 3 BRBS 22 (1975). If credible rebuttal evidence is presented, then the evidence as a whole must be evaluated to determine if the claimant has met the burden of establishing that the medical care for the work-related injury is both reasonable and necessary. Where the credible evidence of record is in "equipoise," that is evenly balanced, the party proponent with the burden of proof (persuasion) must lose. *Schaffer v. Weast*, 546 U.S. 49 (2005); *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 281 (1994).

In this case, Claimant put on evidence that his treating orthopedist, Dr. Wardell, recommended the ECRB repair surgery in 2011. (CX 1, EX 7). This recommendation is the only medical

evidence directly supporting Claimant's need for surgery. The Employer submitted as rebuttal evidence two reports from Dr. Baddar opining that surgery would not help Claimant. (EX 8, EX 9). Dr. Baddar reasoned that Claimant's symptoms of increased pain and loss of motion in his elbow were the result of arthritic spur formation, not epicondylitis. (EX 8 at 16-17, EX 9 at 3). Dr. Baddar believed that surgery would not prove beneficial because it would not cure Claimant's underlying arthritis. Because the Employer has presented this credible rebuttal evidence, the evidence as a whole must be evaluated to determine if Claimant has met the burden of establishing the recommended surgery is reasonable and necessary.

Dr. Wardell's recommendation of surgery appears in his treatment notes. (CX 1, EX 7). He did not provide any details about what the surgery entailed or explain how it was expected to help Claimant's condition. His treatment notes document Claimant's symptoms of lateral epicondyle tenderness, pain, swelling, and mild loss of motion in the elbow, and show that more conservative treatment options had little impact on Claimant's condition. However, Dr. Wardell did not attribute Claimant's symptoms to epicondylitis or relate them to a need for surgery, nor did he explain how the symptoms and the condition led him to choose ECRB repair surgery as the preferred course of treatment. Also, he did not directly state that the surgery was necessary. Because Dr. Wardell did not offer any reasoning to support his recommendation or to show the necessity of the surgery, thus his medical opinion is not well-reasoned.

The other medical evidence does not establish the necessity of surgery, either. Claimant testified that his pain management specialist, Dr. Pennington, agreed he needed surgery. (EX 10 at 21-22, TR at 18-19). However, Dr. Pennington's progress notes do not explain the need for surgery but merely comment that after a slight increase in the patient's pain symptoms, he planned to discuss potential surgical options with his doctor. (CX 5, EX 6). The less recent medical evidence flatly contradicts Dr. Wardell's recommendation of surgery. Dr. Davlin indicated in his 2004 report that future surgery would not be useful because Claimant was already at maximum medical improvement (MMI) for his work-related elbow injury at that time, although he noted as an aside a finding of degenerative osteoarthritis that could cause increasing stiffness and pain in Claimant's elbow in the future. (EX 12 at 4-5). Dr. Stiles, who served as Claimant's treating orthopedist from shortly after his injury in summer 2000 until late 2010, performed a right elbow arthroscopy in 2001 (CX 3, EX 2) but declined to recommend further surgery on the elbow. On October 17, 2007, Dr. Stiles reported that an MRI showed right lateral epicondylitis, but noted that this was an old injury and that the patient did not believe his symptoms warranted surgery. (CX 2). On February 7, 2009, Dr. Stiles reported MRI results substantially the same as before, but again declined to recommend surgery, stating that in his opinion surgical intervention would not help Claimant very much. (EX 3 at 5). On January 26, 2010, he reiterated that he did not feel Claimant's symptoms warranted further surgery. (EX 3 at 6). His treatment notes do not mention surgery after this date. It appears that the only change in Claimant's symptoms since this time has been a slight increase in pain and mild limitation of motion in his elbow. As Dr. Baddar pointed out, these symptoms are consistent with arthritic changes and thus may not even represent a worsening of Claimant's work-related injury. (EX 8 at 16-17). Based on all the foregoing evidence, it is not clear that surgery would benefit Claimant.

We are left with a collection of evidence showing Claimant's symptoms did not warrant surgery before 2011, along with Dr. Wardell's recommendation of surgery without further explanation

and without evidence that Claimant's condition changed significantly in 2011. As discussed above, Claimant bears the burden of proving by a preponderance of the evidence that medical treatment is reasonable and necessary. After evaluation of the evidence as a whole, this Administrative Law Judge finds that the Claimant has not established the reasonableness and necessity of the recommended right elbow ECRB repair surgery by a preponderance of the evidence. Accordingly, his claim for medical benefits in the form of right elbow ECRB repair surgery must be denied.

CONCLUSION AND FINDINGS OF FACT

After deliberation on all the evidence of record, including post-hearing briefs of counsel, this Administrative Law judge finds:

1. Claimant gave the Employer timely notice and filed a timely claim for benefits under the Longshore and Harbor Workers' Compensation Act.

2. The claim properly falls under the jurisdiction of the LHWCA.

3. Claimant sustained a compensable work-related injury to his right elbow on June 6, 2000 while performing his assigned duties at the Employer's marine terminal.

4. Claimant still suffers from harm and associated pain in his right elbow arising out of the June 6, 2000 work-related injury.

5. Claimant has failed to establish that the right elbow ECRB surgery is a reasonable and necessary medical treatment under the LHWCA.

6. Claimant is not entitled to compensation for medical expenses for the right elbow ECRB surgery.

ORDER

It is hereby ORDERED that this claim for medical benefits under the LHWCA in the form of right elbow ECRB surgery based on the June 6, 2000 work-related injury is **DENIED**.

Digitally signed by Alan L. Bergstrom
DN: CN=Alan L. Bergstrom,
OU=Administrative Law Judge, O=Office
of Administrative Law Judges,
L=Newport News, S=VA, C=US
Location: Newport News VA

ALAN L. BERGSTROM
Administrative Law Judge

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