

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JIMMY L. GARDNER and TENNESSEE VALLEY AUTHORITY,
PARADISE FOSSIL PLANT, Drakesboro, Ky.

*Docket No. 95-2360; Submitted on the Record;
Issued January 12, 1998*

DECISION and ORDER

Before WILLIE T.C. THOMAS, MICHAEL E. GROOM,
BRADLEY T. KNOTT

The issue is whether appellant has met his burden of proof to establish that he sustained a medical condition in the course of his federal employment.

On December 17, 1990 appellant, then a 43-year-old heavy equipment operator, filed a notice of traumatic injury (Form CA-1) alleging that on October 5, 1990, he injured his neck when the wheel of the rig he was driving dropped into a hole, jarring and jerking him. Appellant further stated that his neck began to hurt that same night and that he had difficulty turning his head. Appellant stopped work on October 5, 1990 and has not returned.¹ By letter dated February 11, 1991, the employing establishment controverted appellant's claim, in part because appellant had failed to credibly establish the date of injury. In support of his claim, appellant submitted treatment notes from the employee health unit, as well as additional reports from his treating physicians.

A health unit note dated October 9, 1990 indicates that appellant presented with mild tenderness over the left elbow joint, extending down the forearm. Appellant was diagnosed with left elbow tendinitis and was advised to rest, or make limited use of, his left arm for two weeks.

¹ The record contains several references to an earlier claim filed for service-related injury to the neck. In a decision dated December 10, 1991, the Office hearing representative referenced an earlier claim (Form CA-1) filed on December 13, 1980, in which appellant apparently stated that on June 1, 1990, while riding in a 657 scraper he was jerked around due to ungraded road conditions, injuring his neck. Appellant testified to this prior injury at the hearing, but the record does not contain the claim itself.

Appellant was next seen on November 14, 1990, by Dr. Thad F. Connally, Jr., a Board-certified orthopedic surgeon to whom he had been referred by his private physician, Dr. Karen Northern, for assessment of the pain in his left arm. In a letter to Dr. Northern dated November 19, 1990, Dr. Connally stated that appellant had been twice examined and that the x-rays, bone scan and magnetic resonance imaging (MRI) scan of the forearm revealed no abnormalities. He stated that appellant had poorly localized pain in the violar proximal forearm with no swelling, redness, heat, deformities or other external abnormal appearance and full range of motion of the elbow and wrist. Dr. Connally added that he did not know of any other diagnostic tests which would assist in establishing a diagnosis.

On November 29, 1990 appellant was evaluated by Dr. Walter Warren, a Board-certified neurosurgeon, for numbness, weakness and pain in the left arm. Dr. Warren stated that "about [three to four] months ago the patient began to notice numbness, pain and tingling in the left forearm and wrist." He further noted that appellant had been using a road grater at work and that the shaking of the grater reportedly made the sensations worse. A cervical MRI scan requested by Dr. Warren and performed on November 30, 1990, revealed that appellant had a mild disc bulge at C3-4, C4-5 and C5-6, with secondary compression of the thecal sac but not the spinal cord. No neuroforaminal compression between C4 and C7 was detected.

Appellant returned to the employee health unit on December 13, 1990. A treatment note completed on that date indicates that appellant presented at the health station wearing a soft cervical collar and stated that he had "messed up" a disc in his neck. He further stated that the injury had occurred at work about two months prior and that while he did not know the exact date, he had dates on papers at home. He stated that he thought that the injury occurred the day before his last visit to the health station, which was on October 9, 1990. He further stated that Dr. Northern, who treated him at that time, thought his pain was related to tendinitis of the left elbow and referred him to a specialist. The note indicates that when appellant was asked whether he had reported the injury to his supervisor, he replied that he was not sure whether he had or not. Appellant was advised to furnish the health station with the proper dates of injury.

Appellant returned to the health unit later the same day, December 13, 1990, stating that the dates and forms that he had at home were the dates on the TVA #1444 issued on October 9, 1990. He added that his neck began bothering him in June or July and kept getting worse, but that he did not know the exact date of injury. He related that the injury occurred when the equipment he was driving struck a hole, jerking his neck. He stated that he saw his private physician on October 9, 1990 and was seen at the health station that same date. He noted that Dr. Warren, a neurosurgeon to whom he had been referred, diagnosed a disc problem in his neck and restricted him from working until after his next appointment on January 4, 1991. The health station personnel did not examine appellant during this visit, but advised him to continue his prescribed medication, keep his appointment with Dr. Warren, bring in the release statement when he returned to work and to inform the health station when he knew the precise date and time of the injury.

Appellant returned to the health station on December 17, 1990. He was wearing his cervical collar, but was not examined. Health station personnel noted that appellant filled out a new CA-1 form to take the place of the CA-1 form he had previously filed on December 13, 1990.

By letter dated March 8, 1991, the Office requested that appellant submit additional factual and medical information in support of his claim, including among other things, a comprehensive medical report containing a physician's well-rationalized opinion as to the causal relationship between appellant's alleged work injury and the established diagnosis.

Subsequent to the Office's request, appellant submitted a narrative report from Dr. Warren dated January 17, 1991, in which the physician noted that appellant had been admitted to the hospital for a cervical myelogram. He noted that he had been treating appellant since November 29, 1990 for complaints of numbness, weakness and pain in the entire left arm. He added that appellant's condition started slowly after a period of heavy machinery use at work, where he is subject to being shaken. Upon examination, Dr. Warren noted that appellant had normal gait, normal strength of upper and lower extremities and normal sensation to light touch and vibration. Dr. Warren diagnosed cervical pain with radiation to the left arm with disk bulge at C3-4, C4-5 and C5-6 by MRI scan of November 30, 1990, unresolved by cervical collar and medication.

In a decision dated April 10, 1991, the Office denied appellant's claim on the grounds that, despite the Office's request for additional information, the file lacked sufficient medical and factual evidence to establish that appellant sustained a work-related injury, as alleged.

Subsequent to the Office's decision, appellant submitted his narrative responses to the Office's March 8, 1991 request for additional information, as well as a letter dated January 3, 1991, from Dr. Warren. In his narrative statement, appellant asserted, in pertinent part, that he had informed his supervisor of the accident on the day following the accident, that his back, neck and arm were jerked when his rig dropped into a hole and that the resulting pain caused him to seek medical treatment on the first working day following the accident.

In his January 3, 1991 report, Dr. Warren summarized the results of his November 29 and 30, 1990 examinations and noted that appellant tested normal for strength, sensation and gentle examination of the nervous and peripheral systems. Noting the MRI scan results, Dr. Warren diagnosed cervical disc disease with a clinical neuritis. In response to an inquiry as to whether appellant's condition was work related, Dr. Warren stated: "Vertical vibration may make such a disk degeneration worse. It could also, over a long period of time, cause it."

On May 3, 1991 appellant requested an oral hearing.

In further support of his claim, appellant submitted a medical report dated June 27, 1991 from Dr. William A. Schwank, a Board-certified neurosurgeon to whom he had been referred by Dr. Warren. In his report, Dr. Schwank summarized his treatment of appellant, which began on February 1, 1991. The physician provided a history of injury, as related to him by appellant, as having occurred on October 5, 1990 when appellant's rig hit a hole, jerking him forward. He further noted appellant's statement that at the time of the incident, he felt his neck pop, he felt

immediate discomfort and was unable to look backwards for the rest of the night. Dr. Schwank provided a review of appellant's course of treatment and concluded that "testing shows disk bulges at C3-4, C4-5 and C5-6, greatest at C5-6 and I do feel [appellant's] symptoms are secondary to a work-related injury."

In a decision dated December 10, 1991, the Office hearing representative affirmed the Office's April 10, 1991 denial of appellant's claim on the grounds that the file contains no rationalized medical evidence to establish that appellant sustained an injury as alleged.

By letter received October 25, 1993, appellant requested reconsideration of the Office hearing representative's December 10, 1991 decision. In support of his request, appellant submitted a favorable Social Security Disability decision dated February 20, 1993, in which appellant was found to be totally disabled for work due to "degenerative disease of the cervical spine with a deteriorated disc." The decision further noted that appellant had not worked since October 5, 1990.

In a merit decision dated November 23, 1993, the Office found the evidence submitted in support of appellant's request insufficient to warrant modification of the prior decision. In an accompanying memorandum, the Office stated that although the administrative law judge who presided over appellant's Social Security Disability case noted that appellant had not worked since October 5, 1990, the same date appellant alleged he was injured, there is nothing in the decision which shows that the disability appellant has was a result of an injury on October 5, 1990 and, in fact, the decision does not mention an employment-related incident at all. The Office further noted that the file still lacked rationalized medical opinion evidence, based on a complete and accurate factual background, showing a causal relation between appellant's diagnosed medical condition and employment-related factors.

By letter received August 4, 1994, appellant again requested reconsideration of the Office's prior decision. In support of his request, appellant submitted additional medical evidence, including a deposition by Dr. Schwank and copies of his treatment notes dating from February 1, 1991 through March 18, 1994. The treatment notes included an October 23, 1991 hospital discharge summary and the results of a cervical myelogram and a cervical computerized tomography scan performed on October 19, 1993.

In a merit decision dated March 24, 1995, the Office found the newly submitted evidence insufficient to warrant modification of the prior decisions. The Office specifically found that while the factual history establishes that appellant was operating a scraper at work on October 5, 1990 and that he may have hit a hole, there is insufficient factual evidence to firmly establish that the specific event occurred at the time, place and in the manner alleged. In addition, the Office found the medical evidence of file, including the newly submitted medical evidence from Dr. Schwank, insufficiently rationalized to establish that appellant sustained a medical condition as a result of the alleged incident.

The Board finds that this case is not in posture for decision and must be remanded for further evidentiary development.

In the instant case, appellant filed a claim for a traumatic injury (Form CA-1) alleging that an employment incident on October 5, 1990 caused injury to his neck. Although the factual evidence may be insufficient to firmly establish that the specific event occurred at the time, place and in the manner alleged and the medical evidence may be insufficiently rationalized to establish that a medical condition occurred as a result of the alleged specific employment incident, there is evidence in the file indicating that this claim would be better adjudicated as a claim for occupational disease. Specifically, appellant has submitted uncontroverted medical evidence from Dr. Warren indicating that appellant's operation of vibratory machinery may have aggravated, or, over a long period of time, even have caused his degenerative disc disease. Although the medical evidence does not contain sufficient detail and rationale² to meet appellant's burden of proof in establishing that he developed an occupational disease, it is sufficient to require further development of the evidence. It is well established that proceedings under the Federal Employees' Compensation Act are not adversarial and while appellant has the burden of proof in establishing entitlement to compensation, the Office shares responsibility in the development of the evidence.³ In addition, as indicated in the Office's procedure manual, it is the duty of the claims examiner to develop a claim based on the facts at hand and not on the basis of the type of claim filed.⁴ For example, if Form CA-1, claim for traumatic injury, is received by the Office and Form CA-2, claim for occupational disease, is actually required, the claims examiner should not deny the claim on the basis that fact of injury is not established.⁵ As the uncontroverted medical evidence in this case constitutes a sufficient basis to require further development of the evidence, the case must be remanded.

On remand the Office should conduct such further medical development as is necessary to determine whether appellant developed an occupational disease, or sustained an employment-related aggravation of a preexisting condition and, if so, the extent and duration of any such aggravation.

² See *George Randolph Taylor*, 6 ECAB 986, 988 (1954) (where the Board found that a medical opinion not fortified by medical rationale is of little probative value).

³ *John J. Carlone*, 41 ECAB 354, 359-60 (1989).

⁴ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Development of Claims*, Chapter 2.800.4 (April 1993).

⁵ See FECA Bulletin No. 96-10 (issued May 9, 1996).

The September 13, 1994 decision of the Office of Workers' Compensation Programs is set aside and the case remanded for further development consistent with this decision to be followed by a *de novo* decision.

Dated, Washington, D.C.
January 12, 1998

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member

Bradley T. Knott
Alternate Member