U.S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JEANETTE M. WHITE and U.S. POSTAL SERVICE,
POST OFFICE, Los Angeles, Calif.

Docket No. 96-1125; Submitted on the Record;
Issued August 27, 1998

DECISION and ORDER

Before DAVID S. GERSON, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether the Office of Workers' Compensation Programs properly terminated appellant's compensation benefits.

On January 22, 1992 appellant, a letter carrier, sustained a cervical strain, lumbar strain and left shoulder strain while in the performance of duty when her postal jeep was hit by another vehicle. She was disabled from January 23 through March 1, 1992, returned to light duty through April 6, 1992 was again disabled from April 7 through August 15, 1992 and returned to light duty on August 16, 1992. On August 29, 1992 appellant sustained a cervical strain and a left shoulder contusion while in the performance of duty when she tripped over some trays and fell. She did not return to work.

Following second-opinion examinations in April and May 1993, the Office found that appellant's cervical strain and left shoulder contusion had resolved but accepted that she had sustained additional medical conditions consequential to her January and August 1992 employment injuries, namely, depression and reflex sympathetic dystrophy of the left arm. The Office placed appellant on the periodic compensation rolls.

Appellant's attending physician, Dr. Marshall S. Cherkas, a Board-certified specialist in psychiatry and neurology, sought a neurological consultation with Dr. David E. Glass, also a Board-certified specialist in psychiatry and neurology.[1] In a June 20, 1994 report, Dr. Glass reviewed appellant's history, complaints, current treatment and medications, and her general medical history. He reported his findings on neurological examination. After itemizing the medical records he had carefully reviewed and analyzed, Dr. Glass offered the following diagnoses: (1) history of possible multiple sclerosis in 1986; (2) history of possible transient aggravation of multiple sclerosis by the industrial injury on January 22, 1992; (3) chronic cervical strain secondary to the injuries sustained in January and August 1992; (4) history of

[1] Dr. Cherkas identifies himself as a specialist in psychiatry.

probable cerebral concussion secondary to the head injury sustained in the industrial accident of August 29, 1992; (5) post-concussion syndrome manifested by dizziness, difficulties with recent memory, and headache; (6) tension-type headaches; (7) possible cervical myofascial pain syndrome; (8) conversion disorder manifested by bizarre tremor of the left upper extremity, variable sensory findings that fail to follow any know neuroanatomical distribution and by "give-away" weakness in both left extremities; and (9) major depression.

On the issue of multiple sclerosis, Dr. Glass commented as follows:

> "[Appellant] has a history suggestive of multiple sclerosis which developed in 1986, and then, according to the history I have obtained, became almost completely asymptomatic after approximately one month. According to my history and the records reviewed, the industrial injury of January, 1992 may have caused transient exacerbation of her multiple sclerosis as manifested by band-like sensation and tingling paresthesias in all four extremities. However, the patient's current signs and symptoms would be quite atypical for multiple sclerosis, and I certainly see no objective evidence of a residual demyelinating disorder. Therefore, in my judgment, multiple sclerosis is not playing a role in [appellant's] ongoing disability."

On the issue of causal relationship, Dr. Glass advised Dr. Cherkas as follows:

> "[Appellant's] chronic cervical sprain and her cervical myofascial pain syndrome were certainly caused by the work-related incident of January 22, 1992. These symptoms, and the disability related to them, were exacerbated by the work-related accident of August 29, 1992.
>
> "[Appellant's] left upper extremity tremor, which I believe to be hysterical in etiology, also followed the industrial accident in January of 1992, and is in all probability a manifestation of conversion disorder. It is probable that the conversion disorder is also industrially related, in that it arose in close association with anxiety, depression and significant concerns which closely followed her injury. However, I will defer to your psychiatric expertise here.
>
> "[Appellant] did, in all probability, suffer the equivalent of a cerebral concussion when she struck her head in the work-related incident of August 29, 1992. The post-concussion syndrome which then flowed from the latter condition is also industrially related.
>
> "[Appellant's] tension-type headaches also arose following the initial injury in January of 1992, and, in my opinion, are industrial in causation."

Dr. Glass reported that appellant was probably temporarily totally disabled by her psychiatric and musculoskeletal problems for two or three months after each injury in 1992. He deferred to Dr. Cherkas on whether appellant was temporarily totally disabled by her psychiatric complaints through much of 1993, but stated that currently appellant had probably reached a plateau and could be considered permanent and stationary from a neurological standpoint.

Dr. Glass reported that he thought appellant would be capable of some type of light duty at the employing establishment, in which she would not be required to do heavy lifting, driving or performing tasks requiring significant manual dexterity with the left hand.

On October 28, 1994 Dr. Cherkas advised the Office that he had been treating appellant for approximately two years and that her condition had not improved. If anything, he observed, there was some deterioration. Dr. Cherkas noted that, with the assistance of the neurologist, Dr. Glass, there was an excellent evaluation of appellant's multiple sclerosis, which was minimal. "In effect," Dr. Cherkas stated, "the major disability factors now relate to her extreme depression, dependency and pain disorder." He explained that appellant had required the use of strong anti-depressant medications, along with anti-anxiety and pain medications for her headaches, but was not required to abandon such medication because of her recently discovered pregnancy. Appellant's left arm, he stated, still revealed marked signs of sympathetic dystrophy or some augmentation due to her emotional state or both. "Clearly," he emphasized, "the tremor, weakness and atrophy of her left arm is not simply due to imagination, malingering, etc."

In a follow-up report dated November 17, 1994, Dr. Cherkas advised the Office that appellant's cervical strain, left shoulder contusion and particularly the reflex sympathetic dystrophy had contributed a huge amount of her depression and anxiety. He noted that the reasonably objective report of the neurologist, Dr. Glass, confirmed that there was some emotional augmentation of her physical condition, which might well be attributed to the depression and anxiety. This reflected a somatoform disorder, he stated, meaning that the pain and physical limitation were magnified due to her deteriorated emotional state. Dr. Cherkas added: "The primary precipitant to the above was the motor vehicle accident of [January 22, 1992]. Based upon the neurologist's evaluation of multiple sclerosis, this condition is either quiescent or minimal, such that it has relatively little impact upon her current state of disability."

In a report dated January 24, 1995, Dr. Cherkas advised the Office that appellant's injury of January 22, 1992 had not resolved by October 30, 1992. There was continued shaking of the arm, pain and discomfort, and emotionally appellant had already begun to experience depression. He noted that a second incident occurred on August 29, 1992 and that there was a consequential reflex sympathetic dystrophy as well as a consequential depression, which he stated, was even more augmented due to the considerable physical discomfort in general. Dr. Cherkas indicated that there were objective findings for appellant's orthopedic injuries. He noted that the Office had accepted the condition of reflex sympathetic dystrophy, which was a positive orthopedic finding, the nature of which caused a considerable amount of pain and weakness, which clearly caused emotional problems that affected appellant's ability to perform her job. If there was a true reflex sympathetic dystrophy, Dr. Cherkas stated, he could not understand any orthopedist returning appellant to work even on a restricted basis. Otherwise, he stated, the matter must be considered entirely as a mental problem due to a somatoform type of disorder. "In effect," he explained, "this simply means that having had the injury, her significant emotional response to the injury is to cause a focus on pain, suffering, regression, etc. and leading her to feel helpless and to spend much of her concentration on her weakness, dependency and limitations. All of this has led to depression of such a severe nature that she has been habitually and frequently in consideration of suicide." Dr. Cherkas added that there was no indication that there were

personal factors to account for the depression and anxiety, such that all of appellant's emotional deterioration was due to the job injuries and their sequelae.

The Office referred appellant, together with a statement of accepted facts,[2] issues to be resolved,[3] and copies of medical records, to Dr. Richard G. Ness, a Board-certified specialist in psychiatry and neurology and an assistant clinical professor of psychiatry at the UCLA Neuropsychiatric Institute, for a second-opinion psychiatric evaluation. In a report dated August 21, 1995, Dr. Ness expressly disagreed with the opinion given by Dr. Cherkas. He noted that there had been a major effort to hide and disguise her long-standing and preexisting multiple sclerosis, so that its symptoms were misidentified and misattributed to incidental employment events. Dr. Ness related appellant's history of injury, complaints, background, and findings on mental examination and psychological testing. In reviewing the records submitted by the Office, Dr. Ness made clear that appellant's presenting symptoms were parsimoniously explainable on the basis of a diagnosis of multiple sclerosis and symptomatic exaggeration but that appellant had refused to acknowledge this condition. Without this critical history, Dr. Ness explained, physicians were bound to reach erroneous conclusions regarding the cause of appellant's symptoms. Critical of the reports of Dr. Cherkas and other physicians, Dr. Ness stated: "I am in respectful disagreement with any opinion offered by Dr. Cherkas or others that this patient's psychiatric status has somehow been caused by work injuries, rather than the more obvious cause, her preexisting MS [multiple sclerosis] and significant life losses." In truth, he stated, appellant's loss of her "former self," as the source of her depression, "is obviously due to the ravages of MS, not a few soft tissue lumps and bruises." Concerning the opinion of Dr. Cherkas that the large majority of the impact of appellant's mental illness was due to industrial factors rather than the multiple sclerosis, Dr. Ness stated:

> "As this opinion defies common medical sense, as it is contrary to the known course of MS, as it is strongly rebutted by the clinical features of this patient's preexisting MS, as it is an opinion produced in part by the patient's own historical misrepresentations, as it is an opinion which is not even consistent with the benign injury mechanics of [January 22, 1992] and [August 29, 1992], I remain in respectful disagreement with the erroneous etiological theories of Dr. Cherkas."

[2] The statement of accepted facts gave no indication that the Office had accepted the consequential conditions of depression and reflex sympathetic dystrophy of the left arm.

[3] Although the Office stated that appellant's work-related orthopedic conditions had resolved, according to her former attending orthopedists, the Board finds no such report addressing the accepted condition of consequential reflex sympathetic dystrophy of the left arm.

Addressing the second-opinion neurological evaluation in May 1993 that lead to the acceptance of a consequential reflex sympathetic dystrophy, Dr. Ness stated:

> "I realize that the patient had provided another incomplete history, but the signs and symptoms of MS literally [sic] leap from the page, and there is no doubt as to the validity of this preexisting and established diagnosis; its course of symptoms is rather classic by textbook criteria, yet [the second-opinion neurologist] comes up with the unusual and unsupported theory of 'reflex sympathetic dystrophy [RSD] secondary to trauma' as the purported cause of MS symptoms. As stated above, this is not a reasonable diagnosis, it does not conform to the medical facts, it is a diagnosis which fails completely to explain the fact that the patient has the purported RSD symptoms not only in simply one limb, but in all four, etc., etc. It is unfortunate that [another second-opinion physician] was thereafter misled as well by his neurological misdiagnosis…."

Dr. Ness also rejected the "false theory" that appellant's accepted depression was industrial, a consequence of her orthopedic injuries.

Dr. Ness disagreed with the opinion of Dr. Glass, neurological consultant to Dr. Cherkas, that multiple sclerosis was not playing a role in appellant's ongoing disability.

Dr. Ness offered a principal diagnosis of depressive disorder due to multiple sclerosis. He also diagnosed hysterical, paranoid and immature personality traits, and multiple sclerosis since 1986. "Two incidental work injury events," he stated, "have no pathological significance to either this woman's MS or to her depression."

In a decision dated November 28, 1995, the Office terminated appellant's compensation benefits on the grounds that the weight of the medical evidence, as represented by the August 21, 1995 report of Dr. Ness, the second-opinion physician, established that appellant no longer had a medical and emotional condition causally related to the accepted work injuries.

The Board finds that the Office improperly terminated appellant's compensation benefits.

It is well established that, once the Office accepts a claim, it has the burden of proof to justify termination or modification of compensation benefits.[4] After it has determined that an employee has disability causally related to his or her federal employment, the Office may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment.[5] The Office's procedure manual provides that, having accepted a

[4] *Harold S. McGough*, 36 ECAB 332 (1984).

[5] *Vivien L. Minor*, 37 ECAB 541 (1986); *David Lee Dawley*, 30 ECAB 530 (1979); *Anna M. Blaine*, 26 ECAB 351 (1975).

claim and initiated payments, the Office may not terminate compensation without a positive demonstration, by the weight of evidence, that entitlement to benefits has ceased.[6] The inadequacy or absence of a report in support of continuing benefits is not sufficient to support termination, and benefits should not be suspended for that reason.[7]

The Office justified its termination of appellant's compensation benefits on the grounds that the August 21, 1995 report of Dr. Ness, the Office second-opinion physician, constituted the weight of the medical evidence. Although Dr. Ness offered a well-reasoned explanation to support that residuals of the accepted employment injuries had ceased, his opinion created a conflict with that given by Dr. Cherkas, appellant's attending physician, who supported that appellant continued to suffer from the accepted conditions of depression and reflex sympathetic dystrophy. In several instances, Dr. Ness expressly and respectfully disagreed with Dr. Cherkas.

Section 8123(a) of the Federal Employees' Compensation Act provides in part:

> "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[8]

Because the Office did not appoint a third physician to address the conflict in medical opinion between Dr. Ness and Dr. Cherkas, the issue of appellant's entitlement to continuing compensation benefits remains unresolved. As the Office carries the burden of proof in this case to justify the action taken by its November 28, 1995 decision, and as the weight of the medical evidence cannot rest with the opinion of the second-opinion physician when that opinion creates an unresolved conflict under 5 U.S.C. § 8123(a), the Board finds that the Office has not met its burden of proof.

[6] Federal (FECA) Procedural Manual, Part 2 – Claims, *Periodic Review of Disability Cases*, Chapter 2.812.3 (July 1993).

[7] Federal (FECA) Procedural Manual, Part 2 -- Claims, *Periodic Review of Disability Cases*, Chapter 2.812.7(c)(1).

[8] 5 U.S.C. § 8123(a).

The November 28, 1995 decision of the Office of Workers' Compensation Programs is reversed.

Dated, Washington, D.C.
August 27, 1998

David S. Gerson
Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member