

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JAMES W. REDMOND and U.S. POSTAL SERVICE,
POST OFFICE, Grand Rapids, MI

*Docket No. 99-819; Submitted on the Record;
Issued December 28, 1999*

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
BRADLEY T. KNOTT

The issues are: (1) whether appellant had any disability or injury residuals after June 26, 1996, causally related to his May 14, 1996 right corneal abrasion, facial abrasions, rib contusions or right knee sprain injuries; (2) whether appellant has established that he sustained closed head injury on May 14, 1996 causing a subsequent psychiatric or psychological condition; and (3) whether appellant has established that he sustained an accident-related aggravation of a preexisting psychological or psychiatric condition.

On May 14, 1996 appellant, then a 24-year-old part-time rural carrier who had worked for the employing establishment for about two months, was involved in a traffic collision. Contemporaneous medical evidence from physicians indicated that appellant sustained facial abrasions, a right eye injury, rib injury without fracture and a right knee contusion injury. An unsigned medical progress note from "BFW" dated May 15, 1996 noted that appellant sustained injuries to his face and chest the day before in an automobile accident, but was being seen that date for complaints of right knee pain. No signs or symptoms of a closed head injury were noted, and a computerized tomography (CT) scan of the head on June 18, 1996 was reported to be negative. The Office of Workers' Compensation Programs accepted that appellant sustained facial abrasions, right corneal abrasion, rib contusions and right knee sprain.

Appellant returned to work at his private employer for one night on June 13, 1996 but stopped due to right knee swelling.

However, more than one month after the accident on June 20, 1996 a nurse, David C. Hickman, opined that appellant had clinical symptoms of a closed head injury. Mr. Hickman also reported that appellant had a subdural hematoma, a change in mental status, a significant mood change, an uncontrollable temper, a change in personality and a questionable seizure disorder.

Appellant claimed that he had no previous problems before the accident. However, evidence of record demonstrates that he had had a prior learning disability with an attention deficit and hyperactivity disorder, a right arm fracture on August 29, 1995 during steer wrestling, and a December 31, 1995 fall.

A neuropsychological consultation performed by Dr. Andrew A. Swihart, a clinical neuropsychologist, on June 25, 1996, noted as history that appellant had experienced a prior episode of loss of consciousness when struck by a steer horn on his chin while showing the steer at a fair. Dr. Swihart noted that appellant had been held back in Grade 5 due to academic difficulty and graduated from high school with grades in the "D" range. He noted that appellant had had a long-standing history of learning disability as well as attention deficit hyperactivity disorder and was diagnosed as dyslexic between Grades 11 and 12. Dr. Swihart indicated that appellant reportedly did not accept responsibility for himself, that he apparently day dreamed and neglected his work, that he was teased by other children due to his obesity and had been involved in multiple fights, that he had few close friends and was described as very angry and having a "bad temper" and that he was noted to swing at others if provoked. Dr. Swihart noted that appellant never learned to read adequately and consequently had great difficulty in school, that he had worked as a machinist for five years and had been employed by the employing establishment for just a couple of months. He noted that appellant was evaluated by an osteopathic physician on February 1, 1984 and was found to demonstrate physiological and perceptual underdevelopment of visual skills, with subnormal memory for unrelated sentences and marked difficulty in a digit span test.

Dr. Swihart noted that appellant suspected that he experienced a loss of consciousness during the employment accident, but that there was no medical record confirmation of such and no witnesses who could confirm this, and that there was no evidence of significant retrograde amnesia or post-traumatic amnesia, as appellant recalled the accident, recalled exiting the vehicle and speaking with the other driver, walking to a house and getting cleaned up. He concluded that no confirmed history of loss of consciousness was evident. Dr. Swihart noted that appellant reported mood swings following the accident which were noticed more by his parents than by him, and that he reported left hand decreased strength since the accident which he noticed when attempting to steer wrestle. Appellant denied postinjury changes in sense of taste and smell, memory impairment, changes in language comprehension or expression, consistent visuoperceptual changes, or changes in mood or emotion, but he reported a little bit of decline in attention and concentration skills, especially when mail sorting and indicated that he suspected that it might be "a boredom type thing." Dr. Swihart noted that appellant indicated that his mathematical skills had declined a little bit, but emphasized that he had not used them much since the injury, and described himself as more "hyper," reporting an episode of behavioral discontrol in which he became quite aggressive with his father while attempting to repair a farm fence, and attempted to destroy the fence in his frustration. Dr. Swihart noted that appellant's mother reported numerous postinjury changes in her son, reported that he was never violent or aggressive preinjury and reported that he had been on Ritalin from ages 7 until 15 or 16.

After reviewing past psychological and medical records, Dr. Swihart noted in a July 30, 1996 report that appellant had been a child with a central nervous system based memory difficulty, as well as reduced self-confidence and self-esteem secondary to awareness of his

difficulties and their functional effects. Dr. Swihart noted that at the end of Grade 11 appellant was found to have numerous language-related difficulties, pronunciation skills difficulties, and difficulty with ability to understand sounds/symbol relationships and blending of syllables in attempting to pronounce English graphemes. He noted that appellant had preinjury reduced word comprehension skills, reduced short written passage comprehension, reduced paragraph comprehension, reduced spelling ability and reduced sentence recall, and that he had a full scale I.Q. of 86. Dr. Swihart noted that appellant had been certified as learning disabled for the purpose of receiving special educational services during Grade 12. Dr. Swihart discussed appellant's current testing results and opined that his Minnesota Multiphasic Personality Inventory (MMPI) results were suggestive of possible response invalidity, due to the atypical manner of his responses. He concluded:

“Review of clinical history fails to reveal clear documentation of loss of consciousness. There is no evidence of post-traumatic or retrograde amnesia. Initial hospital evaluation, including neuroradiological studies, fails to reveal evidence of closed head injury. Review of psychoeducational history reveals previous psychometric indication of learning disability, attention-deficit/hyperactivity disorder and problematic behavior. Furthermore, preinjury documentation of difficulties with language related and memory tasks is noted. Currently neuropsychological evaluation fails to reveal finds which are strongly suggestive of head injury. Rather, [appellant's] ability to learn, retain and recall meaningful verbal material, as well as visual material, appears grossly normal at this time. However, current evaluation does reveal evidence suggestive of ongoing deficits in attention, consistent with a past history of attention-deficit/hyperactivity disorder, as well as stigmata of learning disability (poor spelling, poor written expression, decreased verbal divergent thinking fluency, difficulty with simple visual form discrimination). In terms of mood and emotion, the possibility of significant psychopathology is suggested by [appellant's] personality profile and clinical interview reveals evidence of difficulties with anger, impulse control, anxiousness and dysphoria. In summary, I believe diagnoses of attention-deficit/hyperactivity disorder (primary inattentive type)(ADHD), learning disorder (primarily affecting reading and spelling), and adjustment disorder are appropriate. I do not believe that [appellant's] current presentation is consistent with a conclusion of significant cognitive or behavioral difficulties attributable to closed head injury.”

Dr. Swihart opined that appellant's current symptomatology is consistent with an exacerbation of his previous attentional problems and he recommended referral for pharmacological as well as psychotherapeutic intervention.

By report dated August 27, 1996, Mr. Hickman, the nurse, continued to report closed head injury and objectively noted a quick temper, difficulty driving and maintaining his concentration and difficulty dealing with his emotions, but he also noted no evidence of any localizing neurological deficit at that time.

An August 29, 1996 insurance form report from Dr. Theodore A. Bash, an osteopath, noted "May of [19]96 [motor vehicle accident] MVA -- since then significant personality changes," and diagnosed "closed head injury with personality changes." However, no further evidence or data supporting these diagnoses was provided, and no explanation as to how appellant's present symptomatology differed from his preinjury symptomatology was provided. A civil service disabled dependent application Blue Cross/Blue Shield form for appellant's mother noted that appellant had a closed head injury, an affective disorder and depression and was signed by Dr. Bash. No other information was provided.

By report dated November 25, 1996, Mr. Hickman noted that appellant had been hospitalized for four days on September 2, 1996 for violent behavior. Diagnosis was noted as "concussion, personality changes, violent behavior."

However, in a September 16, 1996 discharge summary Dr. Mitchell Osman, a Board-certified psychiatrist, noted the Axis I diagnoses of impulse control disorder, dysphoric mood disorder, residual attention deficit disorder, history of learning disabilities, verbal areas, speech articulation disorder. Axis III was noted as history of abnormal thyroid, history of motor vehicle accident and head injury. Dr. Osman noted that the post accident CT head scan was negative, cervical spine x-rays were unremarkable and facial bone x-rays were negative for fracture. He noted that appellant's mother suggested that appellant's difficulties were somehow related to his car accident. However, no injury relationship was diagnosed or discussed by Dr. Osman.

A September 20, 1996 witness statement indicated that appellant was observed that date driving a farm tractor on a public street.

A September 27, 1996 unsigned psychosocial assessment and treatment plan apparently by mental health therapist, social worker Dennis Troester, noted that appellant presented post closed head injury, having difficulty adjusting to disability, and getting irritable and aggressive. The therapist noted that appellant had suffered a closed head injury, without citing any documentation of that fact, noted that a CT scan was not performed, which was factually incorrect, and diagnosed a mood disorder due to a generalized medical condition, without identifying to what condition he was referring. The social worker's unsupported clinical impression was that appellant had suffered a severe blow to his head in May 1996, and that since that time had experienced symptoms of a closed head injury. The social worker also misidentified nurse David Hickman as appellant's physician.

In an October 1, 1996 psychiatric report, Dr. Muhammad Syed, a Board-certified psychiatrist, reported a history as proffered by appellant's mother, reported symptoms and problems as proffered by appellant's mother, and diagnosed Axis I as impulse control disorder, adjustment disorder with mixed emotion, attention deficit disorder, and history of learning disability and speech articulation disorder. He diagnosed Axis II as "rule out post-traumatic stress disorder, although patient does not seem to have a lot of symptoms indicating as such," and noted Axis III as history of thyroid abnormality and history of motor vehicle accident. No closed head injury was diagnosed. In an October 15, 1996 follow up Dr. Syed noted that appellant reported irritability and moodiness, and that he complained of dizziness when he got up, which Dr. Syed advised was a side effect of medication.

A magnetic resonance imaging (MRI) scan of the brain on October 14, 1996 was reported as being unremarkable.

Further reports from social worker Troester and nurse Hickman were also submitted.

On November 12, 1996 Dr. Syed noted that appellant's mother believed that appellant's behavior had gotten worse and that the medication was ineffective. Also on November 12, 1996 appellant was terminated from his machinist job due to continued absence.

A December 17, 1996 Form CA-20 attending physician's report from Dr. Syed noted as history of injury "psychiatric problem," noted as findings "gives h[istory] of anxiety [and] fear," and diagnosed rule out post-traumatic stress disorder, history of attention deficit and hyperactivity disorder. No closed head injury was noted. A second CA-20 form from Dr. Syed that was dated incorrectly noted that there was no history of preexisting injury, disease or physical impairment and noted, in response to the question of whether the condition found was caused or aggravated by the employment activity described, "Had a car accident -- is difficult to exactly know the correlation." A supplemental Form CA-20a report from Dr. Syed described the nature of appellant's present impairment as "is afraid to drive car. Has periods of confusion [and] fear of driving." Diagnoses were still noted as rule out post-traumatic stress disorder and history of attention deficit and hyperactivity disorder.

A February 17, 1997 report from Dr. Diane B. Webb, a psychologist, did not address appellant's accident or causal relation of his current symptomatology, but noted that it was not anticipated that he would return to his felt sense of "preaccident normal." No explanation of why she felt this way was provided.

A February 20, 1997 CA-20 form report from Dr. Bash noted that appellant had a May 14, 1996 motor vehicle accident "with psychological breakdown post[-]traumatic stress," and noted a diagnosis of post stress syndrome affective disorder.

By letter dated May 2, 1997, the Office advised appellant's mother that, although she claimed that post injury he was dependent upon her and her husband for just about everything, appellant was witnessed driving a tractor on September 20, 1996, eating breakfast at the Café International three to four times per week, frequenting the Sportsman's Restaurant and Lounge on Saturday nights, and playing in a pool league there, and building a deck on October 16, 1996. The Office asked whether appellant had operated any other farm machinery since his accident, how appellant got to the restaurant and lounge, how he got to the deck work site and what type of work he was performing. In response appellant's mother replied on May 12, 1997 that when appellant drove, one of his parents followed him, that they drove him to the restaurant and/or lounge, that friends also drove him there, that the deck being build was at her home and that he was being instructed by his grandfather, and that she was tired of harassment by the Office since appellant lost his independence. She insisted that the employing establishment was responsible for appellant's condition, and that since she was being falsely accused of improperly representing appellant's claim, she was sending all letters to her congressional representatives.

On June 18, 1997 the Office referred appellant, together with a statement of accepted facts and questions to be addressed, to Dr. Jay A. Inwald, a neuropsychologist, for a second opinion evaluation.

By report dated July 7, 1997, Dr. Inwald reviewed appellant's records, reported post injury complaints of face and right rib pain, noted that pupils were normal, funduscopic examination was normal, and cranial nerves were unremarkable and noted that discharge diagnoses were right corneal abrasion, facial abrasions and right rib contusion. He noted that thereafter appellant complained of right knee pain, with a diagnosis of right knee contusion and sprain. Dr. Inwald noted that at evaluation appellant reported problems with frustration tolerance and anger control, acting like a little kid, and paying attention, and that he had trouble with authority. He noted that upon questioning appellant's reported headaches appeared to be of a sinus nature, but that appellant claimed that the headaches emanated from the occipital area and radiated over to the right forehead and occurred once every one to two weeks. Dr. Inwald noted that appellant reported infrequent mild right eye visual blurring during sunny days, terrible memory, trouble making decisions resulting in him becoming angry and generally feeling anxious. He noted that appellant was driving, but reported that he did not pay attention well, and that he had had weight gain since the accident. Dr. Inwald noted that appellant denied any prior loss of consciousness at the time of evaluation, but admitted that he had had memory problems related to his ADHD, and noted that the record showed that appellant had been struck by a steer and experienced a brief loss of consciousness. He reviewed appellant's testing results, noting that tests of dissimulation revealed an inconsistent performance with symptom magnification on some measures. Dr. Inwald noted that appellant's test profile indicated that while his performance was above the chance level, it was below what an individual with severe brain injury would perform and that therefore his performance on that particular test may be indicative of an individual attempting to exaggerate current difficulties. He noted that on the MMPI-2 appellant endorsed items suggestive of magnification of symptoms as well as inconsistency in reporting, but opined that current test data was deemed to be a reliable estimate of appellant's current neuropsychological functioning. Dr. Inwald noted that appellant's full scale I.Q. was 87, which was commensurate with Dr. Swihart's testing and prior testing as a youth, that his current level of functioning appeared to represent his life long abilities, that he had the greatest difficulties in the area of his fund of general knowledge, social reasoning, and numeric/symbolic reasoning, that these scores suggest a consistent stable pattern and that this was not a profile of an individual who experienced some acute deteriorative breakdown. Dr. Inwald noted that appellant's memory testing results were not consistent with memory difficulties associated with traumatic brain injury. He noted that appellant's language functioning reflected a long-standing specific learning disability, and that reading and spelling were unlikely to be affected by cerebral trauma as described by appellant, and noted that appellant's sensory perceptual and motor functioning performance indicated a profile of style rather than being indicative of a mid cerebral cortical impairment. Dr. Inwald noted that appellant demonstrated a significant amount of somatic preoccupation and health concerns, and that his profile reflected an individual with depression, social introversion and a tendency to respond impulsively. He concluded that, based upon the comprehensive standardized battery of neuropsychological tests, there was no evidence to substantiate an acute deterioration of cerebral dysfunction, that appellant's profile was consistent with his history, that his efforts during the evaluation were at times questionable, but that, even based upon the current results, the profile was not consistent with acute cortical

impairment. Dr. Inwald noted that appellant did not lose consciousness, that there was not a period of post-traumatic amnesia, nor were there radiographic or neuroimaging studies to support a traumatic brain injury diagnosis. He noted that, in fact, mention of a closed head injury did not occur until later in appellant's treatment, and occurred with appellant's primary care provider and nurse practitioner, and that psychiatric reports fail to confirm this diagnosis. Dr. Inwald opined that appellant did not present with any impairment related to the May 14, 1996 accident, and that, based upon a records review of appellant's previous learning disabilities and problems, the May 14, 1996 accident did not aggravate his prior condition. He opined that appellant's reaction time, visuospatial processing and visual attention appeared to be intact, and opined that he could drive safely, and should be able to return to work in a similar capacity as preaccident. Dr. Inwald noted that appellant had no neuropsychological or psychological diagnosis, and did not recommend neurorehabilitation. He opined that reinforcement for illness behaviors should be carefully avoided and that appellant should be considered for employment with vocational assistance. An accompanying work restriction evaluation noted no activity limitations or restrictions and that appellant's current performance limitations appeared to be related to his preinjury conditions. He opined that appellant could return to work that date.

By decision dated August 13, 1997, the Office disallowed compensation benefits subsequent to June 26, 1996, finding that appellant had no disability from the accepted conditions after that date. The Office found that the record contained medical evidence which supported injury-related disability up to June 25, 1996, the date of Dr. Swihart's first consultation, and that claimed disability due to the accepted conditions after that date had no medical support. It also found that there was no causal relationship between appellant's psychological condition and the May 14, 1996 injury, and that there was no evidence that appellant had sustained a closed head injury on May 14, 1996. The Office found that the reports of Mr. Hickman, the nurse and Mr. Troester, the social worker, were not probative medical evidence, and that the reports of Drs. Bash and Bicknell containing diagnoses of closed head injury were not supported by any objective documentation or rationale, such that they were of diminished probative value and were insufficient to establish that a closed head injury occurred. It found that Dr. Osman indicated that all tests came back negative and indicated that it was uncertain as to any contribution to appellant's current psychological condition, and that Dr. Syed did not diagnose any closed head injury, neither of which supported that appellant sustained a closed head injury. The Office found that the weight of the medical evidence was constituted by the reports of Drs. Swihart, who determined on July 30, 1996 that there was no evidence of a closed head injury or neuropsychological changes due to the May 14, 1996 accident and Dr. Inwald, who determined on July 7, 1997 that appellant did not present with any traumatic closed head cerebro-cortical impairment related to the May 14, 1996 accident and that, based upon a records review of appellant's previous learning disabilities and problems, the May 14, 1996 accident did not aggravate his prior condition.

By letter dated September 6, 1997, appellant's mother, on behalf of appellant, requested reconsideration. She alleged that appellant was a different person since the accident and needed special attention, alleged that Dr. Inwald's report was inaccurate, and quoted the reports of the nurse and the social worker containing notation of a closed head injury. In support appellant's mother submitted a very large packet of material, virtually all of which was duplicative of evidence already of record and previously considered by the Office. New evidence consisted of

a June 12, 1997 report from Dr. Harold B. Lenhart, a Board-certified psychiatrist, which noted appellant's version of his history, including a closed head injury a year earlier in a motor vehicle accident, and which indicated that several months before he had sustained another head injury by striking his head on a wooden beam in the barn. No causal relationship between appellant's personality changes and his motor vehicle accident was discussed, with Dr. Lenhart merely diagnosing on Axis I "Mood disorder depressed type secondary to closed head injury, personality change, explosive type secondary to closed head injury." A June 5, 1997 report from Dr. James M. Bender, an osteopath, stated that, if he assumed that the above closed head injury diagnosis was correct, appellant needed to be evaluated by a neuropsychologist to document a specific mood disorder secondary to the head injury. Also submitted were new reports from nurses and social workers claiming that appellant had sustained a closed head injury.

By decision dated October 23, 1997, the Office denied appellant's request for modification of the prior decision finding that allegations of Dr. Inwald's inaccuracies were themselves inaccurate, that most of the evidence submitted did not constitute new or relevant evidence, that the new hospital admission evidence noted that there was no physical evidence of a brain injury, but that appellant's mother suggested that appellant's difficulties were somehow related to the car accident. The Office found that an additional report from Dr. Osman noted that contribution of the accident to appellant's problems was uncertain, that social workers and nurses were not physicians under the Federal Employees' Compensation Act and that therefore their opinions did not constitute competent medical evidence, and that notes from Dr. Webb were based upon an undocumented and inaccurate history. The Office also found that off-work slips were not probative of any alleged causal relation.

By letter received on October 22, 1998, appellant, through his mother, again requested reconsideration. Again duplicative evidence was submitted and new evidence in the form of insurance company denials noting that appellant sustained a closed head injury was presented. A psychiatric evaluation from Dr. S. Pavel, specialty unknown, was also submitted which was based upon an inaccurate history of injury not supported by the contemporaneous medical evidence of record. General published information on head injuries was additionally submitted.

By decision dated November 5, 1998, the Office denied modification of the prior decision finding that the evidence submitted in support was insufficient to warrant modification. The Office found that anecdotal evidence from family members was not probative of a causal relationship, that insurance forms were not binding on the Office, and that printed literature was of general application and not specific to appellant's case.

The Board finds that appellant failed to establish that he sustained closed head injury on May 14, 1996 causing a subsequent psychiatric or psychological condition, and that appellant failed to establish that he sustained an accident-related aggravation of a preexisting psychological or psychiatric condition.

An award of compensation may not be based on surmise, conjecture, speculation or appellant's belief of causal relationship.¹ A person who claims benefits under the Act² has the

¹ *William Nimitz, Jr.*, 30 ECAB 567, 570 (1979); *Miriam L. Jackson Gholikely*, 5 ECAB 537, 538-39 (1953).

burden of establishing the essential elements of his claim.³ Appellant must establish that he sustained an injury in the performance of duty and that his disability resulted from such injury.⁴ As part of this burden, a claimant must present rationalized medical opinion evidence, based on a complete factual and medical background, showing causal relationship.⁵ The mere manifestation of a condition during a period of employment does not raise an inference of causal relationship between the condition and the employment.⁶ Neither the fact that the condition became apparent during a period of employment nor appellant's belief that the employment caused or aggravated his condition is sufficient to establish causal relationship.⁷

In this case, appellant has failed to provide any rationalized medical evidence, based upon a complete and factual and medical background, which established either that he sustained closed head injury on May 14, 1996 causing a subsequent psychiatric or psychological condition, or that he sustained an accident-related aggravation of a preexisting psychological or psychiatric condition. There is no contemporaneous medical evidence of record which supports that he sustained a closed head injury on May 14, 1996 or that the accident aggravated any of his preexisting conditions. All of the medical opinion mentioning that appellant sustained a closed head injury was rendered multiple months after the accident, and was not based upon an accurate factual or medical history, but was based upon appellant's version of his history and his allegations, and much of it was not provided by a qualified physician.

Nurse Hickman and social worker Troester repeatedly stated that appellant had sustained a closed head injury on May 14, 1996, and opined that his personality changes were due to this trauma. However, the Board notes that neither nurses nor social workers are considered to be physicians under the Act, and therefore their opinions do not constitute competent medical evidence.⁸

Dr. Bash reported on an August 29, 1996 insurance form that appellant had a closed head injury with personality changes, but he presented no further evidence, data or rationale to support these diagnoses, and he provided no explanation as to how appellant's present symptomatology differed from his preinjury symptomatology. His subsequent reports did not correct these defects. Consequently, his reports are of diminished probative value as they are

² 5 U.S.C. §§ 8101-8193.

³ *Nathaniel Milton*, 37 ECAB 712, 722 (1986); *Paul D. Weiss*, 36 ECAB 720, 721 (1985).

⁴ *Daniel R. Hickman*, 34 ECAB 1220, 1223 (1983).

⁵ *Mary J. Briggs*, 37 ECAB 578, 581 (1986); *Joseph T. Gulla*, 36 ECAB 516, 519 (1985).

⁶ *Edward E. Olson*, 35 ECAB 1099, 1103 (1984).

⁷ *Bruce E. Martin*, 35 ECAB 1090, 1093 (1984); *Dorothy P. Goad*, 5 ECAB 192, 193 (1952).

⁸ See *Sheila A. Johnson*, 46 ECAB 323 (1994); *Sheila Arbour (Victor E. Arbour)*, 43 ECAB 779 (1992); *Debbie J. Hobbs*, 43 ECAB 135 (1991).

unrationalized and are not based upon factual medical evidence documenting such an injury, and are therefore insufficient to establish appellant's claim.⁹

Dr. Osman noted that objective testing post accident was negative for brain injury, and he indicated that it was uncertain as to any contribution to appellant's current psychological condition. This report, therefore, was not supportive of appellant's claims of closed head injury and/or aggravation of underlying psychological problems.

Dr. Syed did not diagnose a closed head injury, and opined that appellant's dizziness was a medication side effect. He also based his report on a history as given by appellant's mother, which was not factually supported by the record, and opined that it was difficult to exactly know the correlation. This report, therefore, also does not support appellant's claim.

Dr. Webb did not address appellant's accident or discuss causal relation, and hence her reports are of diminished probative value and are insufficient to establish appellant's claim.

Dr. Bender noted that he was assuming that the diagnosed closed head injury was correct, which was an assumption not supported by the record, and referred appellant to a neuropsychologist to document a specific mood disorder secondary to a closed head injury. This documentation, however, did not occur.

Dr. Pavel also submitted a report based upon an inaccurate history not supported by the record, and hence it too was of diminished probative value.

Finally, Dr. Lenhart based his opinion on a history unsupported by the record, which diminished its probative value, and he failed to address causal relationship between the accident and appellant's reported personality changes. Consequently, this report is of diminished probative value and is insufficient to establish appellant's claim.

However, Dr. Swihart, a neuropsychologist skilled in the diagnosing of personality changes related to a closed head injury, found in a complete and well-rationalized report based upon an accurate statement of accepted facts, that appellant's presentation was not consistent with a conclusion of significant cognitive or behavioral difficulties attributable to a closed head injury.

This report was consistent with the Office's second opinion report from Dr. Inwald, who also had an accurate history and statement of accepted facts upon which to base his opinion. Dr. Inwald opined, in a thorough and well-rationalized report, that appellant did not present with any impairment related to the May 14, 1996 injury, nor did the accident aggravate his prior condition.

As the reports of Drs. Swihart and Inwald were based on an accurate factual and medical history, were complete, thorough and well rationalized, and found that appellant sustained neither a closed head injury or impairment related to the accident, nor sustained an aggravation due to this accident, and in the absence of any rationalized medical evidence to the contrary, the

⁹ *Clara T. Norga*, 46 ECAB 473 (1995); *Ruby I. Fish*, 46 ECAB 276 (1994).

Office properly found that they constituted the weight of the medical opinion evidence on those issues. Consequently appellant has not established his claims regarding a closed head injury or an aggravation of prior emotional problems.

However, the Board finds that the Office did not meet its burden of proof to terminate compensation and medical benefits related to appellant's accepted conditions of right corneal abrasion, rib contusions and right knee sprain.

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation benefits.¹⁰ 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.¹¹ Further, the right to medical benefits for an accepted condition is not limited to the period of entitlement to compensation for wage loss.¹² To terminate authorization for medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition that require further medical treatment.¹³

The Office failed to meet its burden to terminate both monetary compensation and medical benefits in this case as it did not secure any medical report opinion that appellant had no further disability or injury residuals due to his right corneal abrasion, rib contusions or right knee strain. The only medical reports of record addressed only appellant's psychological problems and not his accepted physical injuries from the accident. Until such a rationalized medical opinion establishing that appellant's accepted physical conditions have resolved without residuals is obtained, appellant remains entitled to benefits.

¹⁰ *Harold S. McGough*, 36 ECAB 332 (1984); see Federal (FECA) Procedure Manual, Chapter 2.812, para. 3 (March 1987).

¹¹ *Vivien L. Minor*, 37 ECAB 541 (1986); *David Lee Dawley*, 30 ECAB 530 (1979); *Anna M. Blaine*, 26 ECAB 351 (1975).

¹² *Marlene G. Owens*, 39 ECAB 1320 (1988).

¹³ See *Calvin S. Mays*, 39 ECAB 993 (1988); *Patricia Brazzell*, 38 ECAB 299 (1986); *Amy R. Rogers*, 32 ECAB 1429 (1981).

Therefore, the decision of the Office of Workers' Compensation Programs dated November 5, 1998 is affirmed in part regarding the rejection of appellant's claim for a closed head injury and for aggravation of a preexisting psychological disorder, but is reversed in part regarding the termination of monetary and medical benefits.

Dated, Washington, D.C.
December 28, 1999

David S. Gerson
Member

Willie T.C. Thomas
Alternate Member

Bradley T. Knott
Alternate Member