

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of HOWARD McCLAIN and DEPARTMENT OF THE ARMY,
QUALITY CONTROL BRANCH, Fort Carson, CO

*Docket No. 99-1995; Submitted on the Record;
Issued April 11, 2000*

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
BRADLEY T. KNOTT

The issues are: (1) whether the Office of Workers' Compensation Programs met its burden of proof in terminating appellant's compensation benefits effective December 6, 1997; and (2) whether appellant met his burden of proof, following the Office's termination of compensation, to establish that he had a work-related disability on or after December 6, 1997.

The Board has duly reviewed the case on appeal and finds that the Office met its burden of proof to terminate appellant's compensation benefits.

On March 26, 1986 appellant, then a 57-year-old equipment repair inspector, filed a claim for traumatic injury alleging that on March 25, 1986 he sustained injuries to his head, shoulders and back when he struck his head on a vehicle door while exiting the vehicle. He stopped work on March 26, 1986.

Appellant sought early medical treatment with Dr. John Drabing, an osteopath, to whom he was referred by his family doctor. In his initial report dated March 27, 1986, Dr. Drabing noted that multiple x-rays of the cervical and thoracic spine revealed mild anterior lipping at C6-7 and also a possible compression fracture at T-7. He noted that the compression fracture could conceivably be new but that this was doubtful and that appellant should undergo a bone scan to determine whether there had been an acute fracture. Dr. Drabing listed his impressions as "rule out fresh compression fracture T-7, somatic dysfunction of the cervical and thoracic spine and mild degenerative change at C6-7 level." He concluded that, if the bone scan showed fresh activity at T-7, appellant should be issued a brace. In a subsequent attending physician's report dated April 1, 1986, Dr. Drabing stated that the bone scan confirmed that the compression deformity at T-7 was not new, but was more than a year old. He listed his diagnoses as old compression fracture T-7, aggravated, somatic dysfunction of cervical and thoracic spine and mild degenerative changes at the C6-7 level. Dr. Drabing indicated by check mark that appellant's disability was related to his employment injury, but further indicated that there would probably be no permanent effects. He concluded that, as no orthopedic surgery was necessary,

he had referred appellant back into the care of his family physician and an osteopath, Dr. Walter Watts.

In attending physician's reports, Form CA-20, dated May 15 and June 12, 1986, Dr. Watts diagnosed acute cervical myositis, fracture at T-7, age undetermined and acute thoracic strain, which he indicated by check mark were related to appellant's employment injury. In a narrative report dated July 23, 1986, he diagnosed acute cervical myositis, acute lumbar myositis, mild, acute thoracic strain and compression fracture, T-7. Dr. Watts stated that appellant's mid thoracic area remained unstable and painful and might take several months to adequately repair.

The Office had initially accepted appellant's claim for a contusion of the occiput, but subsequently expanded the accepted conditions to include lumbar and cervical myositis and thoracic strain. The Office specifically noted that the medical evidence established that the T-7 fracture was an old injury and therefore was not an accepted employment-related injury. Appellant returned to full-time light duty on May 13, 1986, began working four hours a day light duty on November 2, 1987 and stopped work completely on May 12, 1988.

In a letter dated October 15, 1997, the Office proposed to terminate appellant's compensation benefits. After reviewing additional medical evidence submitted by appellant, by decision dated November 26, 1997, the Office terminated appellant's compensation and medical benefits effective December 6, 1997. He requested an oral hearing, which was held on December 9, 1998. In a decision dated March 29, 1999, after reviewing the additional medical report submitted by appellant, an Office hearing representative affirmed the prior decision terminating compensation benefits.

Once the Office accepts a claim, it has the burden of proving that the disability has ceased or lessened in order to justify termination or modification of compensation benefits.¹ 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.² Furthermore, the right to medical benefits for an accepted condition is not limited to the period of entitlement for disability.³ To terminate authorization for medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition which require further medical treatment.⁴

In this case, appellant submitted periodic reports from Dr. Watts documenting his treatment of appellant's various conditions, including cervico-thoracic instability, paresthesias of the hands, recurrent facial numbness, posterior muscle spasms and headaches, shoulder, hand and arm pain and T-7 compression fracture. In a report dated September 11, 1991, submitted in

¹ *Mohamed Yunis*, 42 ECAB 325, 334 (1991).

² *Id.*

³ *Furman G. Peake*, 41 ECAB 361, 364 (1990).

⁴ *Id.*

response to an Office request for a current report, he provided short answers indicating that appellant's current diagnosis of conditions resulting from the March 25, 1986 employment injury were "lumbar and cervical myositis" and stated that these were the only conditions which limited appellant's ability to work. Dr. Watts further indicated that appellant's prognosis was poor, that he would not be able to return to gainful employment and that he would require medical treatment for the rest of his life. In a more recent report dated May 22, 1997, he stated that appellant continued to have cervical-thoracic junction instability and that shoulder and arm disabilities are often associated with severe neck and thoracic pain, restriction and stiffness. Dr. Watts added that appellant's only relief was obtained through osteopathic manipulative treatment to control his unstable spine without further complicating his injury.

On June 26, 1997 in order to obtain a complete picture of appellant's health, the Office referred appellant, together with a statement of accepted facts, the medical opinions of record and a list of issues to be addressed, to Dr. Robert C. Schutt, a Board-certified orthopedic surgeon, for a second opinion examination. In his report dated September 16, 1997, he noted that appellant's medical history revealed that he had diabetes, high blood pressure, stroke, hydrocephalus with shunt and brain aneurysm, prostate surgery, right knee injury and sprained right ankle. Dr. Schutt documented his findings on physical examination, noted that the 1987 magnetic resonance imaging (MRI) scan showed degenerative hard osteophyte at C6-7, that 1988 cervical spine x-rays revealed degenerative changes at C6-7 and that electromyography and nerve conduction studies showed developing polyneuropathy. He diagnosed cervical, thoracic and lumbar strain. In response to the Office's question as to whether there were any objective findings of active and disabling residuals of the accepted contused occiput, lumbar and cervical myositis and thoracic strain, Dr. Schutt responded:

"[Appellant] has no objective findings of active or disabling residuals of a contused occiput, cervical or lumbar myositis or thoracic strain. I have reviewed the objective test findings of x-ray and MRI [scan] and these show a hard osteophyte and degenerative disc disease. The way the injury is described to me that you are concerned about was essentially a muscle strain that would have resolved spontaneously within a few months. The disease that is described on [an] MRI [scan] has been there and certainly he has returned to baseline status."

Dr. Schutt further responded to the Office's questions as to whether appellant's current disability was due to her accepted work injuries, stating:

"I do not believe [appellant] is currently disabled from work as a result of the continuing disabling residuals of the work injury. [He], however, is severely disabled from work due to his age and debilitation. [Appellant] cannot walk across the room without being out of breath. He has hydrocephalus, stroke, an old back fracture, an old knee injury, prostate surgery and there is no way he can return to any gainful employment at the present time."

In response to the Office's notice of proposed termination, appellant submitted a November 13, 1997 narrative report from Dr. Watts. In his report, he stated:

“As you know this injury was 13 years ago and produced significant disability to [appellant]. Perhaps out of proportion to the amount of trauma experienced. As far as we were able to ascertain he had a flexion injury to the cervical spine along with a more significant intra spinal thoracic injury making compression fracture of the body of T7 along with hemorrhagic lesions at the spinal and para vertebral areas from T1-8. Before this time, [appellant] was [a] very vigorous, energetic and aggressive worker, being an inspector of military vehicles at [the employing establishment].... Following this accident he was unable to recover sufficiently to return to full time work. This depressed [appellant] severely, leading, I am sure, to his chronic fibromyalgia of the shoulder, arms, upper thoracic and lower cervical spine. My therapy was directed to restore as much of his normal range of motion as possible. While the gradual onset of diabetes mellitus and C.V.A. had a deleterious effect on [appellant's] general health, it was not responsible for spinal restriction in the cervical, thoracic spine and his shoulder and arm weakness.... He might have benefited from more intensive therapy but this was not possible since he worked long hours at work and lived in Penrose, Co. After caring for [appellant] for all these years, I believe he wants to return to work. However, the residual pain and limited motion as a result of the accident prohibits him from returning to his former physically taxing occupation as an automobile inspector. If you feel [appellant] does not have any disability remaining from his previous injuries, then he is entitled to a work hardening program to see what his potential is. That should give you an objective assessment of his present abilities, which can be compared to a previous assignment at work.”

At the hearing, appellant submitted an additional report from Dr. Watts, dated January 4, 1999. In this report, he referenced his earlier November 13, 1997 report and further stated, in relevant part:

“To add to his history, [appellant] has deteriorated further since 1997. His left shoulder and neck injury has progressed resulting in a frozen left shoulder with excessive fibrosis along with left arm restriction. [Appellant] is unable to lift his left arm above his head or use it for carrying, lifting or pushing without extreme pain. Due to the continued neck restriction on flexion, extension and side bending, he is unsteady on [his] feet. [Appellant] finds it very difficult to drive a car, since he cannot turn his head. Vertigo is usually noted on trying to turn his head. I feel these symptoms are all the result of [appellant's] injuries sustained on March 25, 1986. As mentioned in my earlier letter, I would like to have [him] examined for work hardening to determine his work potential. I am sure this will support my claim that [appellant]'s injuries were so damaging and deleterious at the time of injury that he was permanently disabled from that point even though he had adequate medical care. [He] has become very despondent and withdrawn over the past years. This ... would contribute to [appellant's] inability to work or care for himself. [He] would benefit with an MRI [scan] of the cervical spine,

also an MRI [scan] of the left shoulder and an EMC of both shoulders. This would focus in on the original sites of injury and give us an up to date evaluation of the injuries.”

The Board finds that the weight of the medical opinion evidence rests with Dr. Schutt’s well-rationalized narrative report. He provided a history of injury and appellant’s medical history, reviewed the results of early tests and performed a complete physical examination. Dr. Schutt noted that there were no objective signs of appellant’s accepted contused occiput, cervical and lumbar myositis or thoracic strain and added that the majority of appellant’s accepted conditions were muscle strains and would have resolved within a few months. While he found appellant totally disabled, he specifically stated that appellant’s current condition was the result of age and his many other nonemployment-related medical conditions. Therefore, the Office properly relied on Dr. Schutt’s report in terminating appellant’s benefits. Furthermore, although Dr. Watts continues to assert that all of appellant’s current medical conditions are causally related to his employment injury, as he provides no objective findings and no explanation to support his conclusion, his opinion is not sufficiently rationalized to create a conflict with that of Dr. Schutt. As Dr. Schutt stated that appellant had no objective signs of his accepted conditions and further stated that his current disability was not due to any of his accepted conditions, the Office met its burden of proof to terminate appellant’s compensation benefits.

The decision of the Office of Workers’ Compensation Programs dated April 1, 1999 is hereby affirmed.

Dated, Washington, D.C.
April 11, 2000

Michael J. Walsh
Chairman

David S. Gerson
Member

Bradley T. Knott
Alternate Member