U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of LISA M. BARONAS and DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, North Hampton, MA

Docket No. 99-1496; Submitted on the Record;
Issued September 25, 2000

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
MICHAEL E. GROOM

The issue is whether the Office of Workers' Compensation Programs properly terminated appellant's benefits effective December 10, 1997.

On September 18, 1996 appellant, then a 30-year-old nursing assistant, filed a notice of traumatic injury alleging that she injured the left side of her neck on that date while moving a patient from a gurney to a bed in the course of her federal employment.

On September 24, 1996 Dr. Julie Stanton, appellant's treating physician and a Board-certified family practitioner, stated that appellant was disabled for two days due to a neck strain. On October 24, 1996 Dr. Stanton diagnosed a cervical strain and stated that appellant was disabled from work for two weeks. On October 29, 1996 she repeated her diagnosis, but indicated that appellant was totally disabled for an unknown duration.

On November 8, 1996 the Office accepted the claim for a cervical strain. Appellant subsequently received compensation for total temporary disability.

On November 12, 1996 Dr. Stanton completed an attending physician's supplemental report diagnosing a neck strain and stating that appellant continued to be totally disabled due to her employment injury. She submitted subsequent attending physician's reports and attending physician's supplemental reports restating her conclusion.

On March 26, 1997 Dr. Charles A. Mick, a Board-certified orthopedic surgeon, treated appellant for neck and left arm pain. Dr. Mick noted the history of the injury and that appellant's pain increased with activity. He reported that appellant was unable to work due to this pain. Dr. Mick stated that an earlier magnetic resonance imaging (MRI) showed mild bulging of the C5-6 level, without any compression of the spinal cords or nerve roots. On physical examination, Dr. Mick found good neck motion, with good flexion, extension and rotation; and lateral bending showing mild limitations without significant pain. He noted a tender area to

palpation over the C5-6 level. Dr. Mick's neurologic testing in the upper extremity showed normal reflexes, normal motor strength and normal sensation. He stated that Tinel's sign was negative at the wrist and mildly positive, bilaterally behind the elbow. Dr. Mick further stated that Phalen's test was mildly positive on the left side after about 10 seconds. He indicated that x-rays of the cervical spine were unremarkable. Dr. Mick diagnosed neck and left arm pain following a work-related injury. He stated that the etiology for the radicular sounding pain in the left arm was not clear.

On June 18, 1997 Dr. Raymond D. Pierson, a physician Board-certified in physical medicine and rehabilitation, noted the history of appellant's injury and conducted a physical examination. On examination, Dr. Pierson found a normal range of motion and no evidence of dyssynergy. He found tenderness over the C4 and C5 spinous processes and that palpation of these areas, as well as the periscapular regions, failed to elicit complaints of left upper extremity pain. Dr. Pierson noted normal motor, sensory and reflex tests in the upper extremities. He found that Tinel's and median nerve compression signs were negative bilaterally. Dr. Pierson indicated that Phalen's test elicited reproduction of paresthesias in the ring finger of the left hand at 30 seconds. He found that nerve conduction and electromyography (EMG) testing of the left upper extremity and left cervical paraspinous areas was normal and that there was no evidence of an acute or chronic neuropathic or myopathic process.

On July 7, 1997 Dr. Stanton treated appellant for persistent pain in her neck and left arm and intermittent symptoms of numbness in the left arm. She again diagnosed a cervical strain, but noted that a cervical spine x-ray taken on October 7, 1997 was unremarkable. Dr. Stanton further stated that an MRI showed a minimal bulging disc at the C5-6 level, but that this did not cause appellant's symptoms. She stated that Dr. Mick's EMG and nerve conduction study revealed no nerve damage. Dr. Stanton recorded, however, that activities like typing or writing caused significant pain. She opined that appellant continued to be disabled from the job she held when injured. Dr. Stanton repeated her diagnosis in attending physician's supplemental reports.

On August 7, 1997 Dr. Mick again treated appellant for neck and right arm pain. He noted that activity heightened appellant's pain and that she was unable to do any work on her computer or spend time on the phone. Dr. Mick stated that an EMG/nerve conduction study failed to show signs of nerve root dysfunction, but that an MRI showed a bulging disc. He stated that this prevented appellant from returning to her previous employment.

On August 8, 1997 the Office referred appellant to Dr. Michael R. Baumgaertner, a Board-certified orthopedic surgeon, for a second opinion examination. On August 28, 1997 Dr. Baumgaertner reviewed the history of appellant's employment history and the treatment that she received. He noted that appellant's symptoms increased with activity and that she had an independent sharp pain in the midline of the posterior cervical spine at approximately the C4 level. Dr. Baumgaertner noted that appellant failed to make a full effort on examination. He noted a mild hesitation to full right-sided rotation with cervical motion. Dr. Baumgaertner found that flexion and extension was full. He noted slight discomfort with palpation at the midline in the mid-cervical region. Dr. Baumgaertner's range of motion findings in both upper extremities were unremarkable as were his neurological findings. He diagnosed a chronic cervical strain. Dr. Baumgaertner again noted that there was no significant neurological component to the injury

and that her examination was remarkable only for a slight restriction in full-sided rotation and mild discomfort in the mid-cervical area. Consequently, he stated that he could not make a correlation between the 1996 injury and appellant's present condition. Dr. Baumgaertner concluded that appellant could return to work after a three-month work hardening program.

On September 25, 1997 the Office requested that Dr. Baumgaertner provide additional information.

On October 9, 1997 Dr. Stanton diagnosed persistent neck pain, but stated that she agreed with Dr. Baumgaertner that the objective findings were few. On November 6, 1997 she repeated her diagnosis.

On October 22, 1997 Dr. Baumgaertner again diagnosed a chronic cervical strain. He opined that there was no direct relationship between appellant's current condition and her 1996 injury.

On October 28, 1997 the Office issued a notice of proposed termination of compensation and medical benefits on the basis that appellant's disability was not related to her September 18, 1996 injury. The Office found that Dr. Baumgaertner's rationalized opinion, that appellant's employment-related disability had ceased, constituted the weight of the medical evidence. Appellant was allowed 30 days to submit additional evidence or argument.

Appellant submitted additional attending physician's supplemental reports from Dr. Stanton which indicated that appellant had a totally disabling cervical strain causally related to her September 18, 1996 injury.

By decision dated December 10, 1997, the Office terminated appellant's claim for continuing compensation and medical benefits on the grounds that the evidence failed to demonstrate that her condition was related to her work injury. The Office found that the opinion of Dr. Baumgaertner constituted the weight of the medical evidence.

Appellant's representative subsequently requested an oral hearing, which was held on August 26, 1998.

Appellant submitted attending physician's supplemental reports from Dr. Stanton, which indicated that appellant had a totally disabling cervical strain causally related to her September 18, 1996 injury. Dr. Stanton also submitted a note dated December 10, 1997 diagnosing persistent cervical pain and indicating mild tenderness in both trapezius muscles. In a note dated December 16, 1997, she stated that she treated appellant for numbness in her left hand, focused in her little finger. Dr. Stanton noted pain and stiffness on the left side, and altered temperature and blood supply to the left hand. On examination, she found moderate restriction to left lateral bending. Dr. Stanton noted marked tightness and spasm of the superior trapezial muscles. She indicated that there was a definite loss of radial pulse with hyperabduction testing and diffuse tenderness in the suprasclavicular area on the left.

Appellant also submitted a November 25, 1997 report from Dr. Pierson. He reviewed his previous testing and conducted a physical examination. Dr. Pierson noted mild restrictions in

left lateral bending and left rotation. He stated that foraminal encroachment testing was negative for any radicular complaints. Dr. Pierson stated that reflexes were 1+ and symmetric in the upper extremities and that there were no motor sensory deficits. He noted full shoulder motion on the left and a loss of radial pulse with hyperabduction testing. Dr. Pierson found increased muscle tone and tightness in the left cervical paraspinous muscles, particularly adjacent to the C5 spinous process. He also noted tenderness in the area.

On December 16, 1997 Dr. Pierson noted appellant's history of injury and noted that appellant developed an acute onset of neck and left arm pain following the injury. He stated that appellant's symptoms persisted and that she experienced numbness in her little finger as well as pain radiating from the left supra scapular area into her left upper extremity. Dr. Pierson stated that appellant had alteration in temperature and sympathetic tone in her left arm and had findings consistent with thoracic outlet syndrome. He opined that appellant's injury was directly caused by the September 18, 1996 work incident.

Appellant also submitted a January 14, 1998 report from Dr. Mick reporting that he treated appellant for neck pain and headaches. He noted that neck pain was primarily on the left side and that range of motion was diminished 25 percent in all directions. Dr. Mick found that neurologic examination in appellant's upper extremities was normal and that x-rays of the cervical spine were normal.

On January 28, 1998 Dr. Stanton diagnosed chronic neck pain and stated that her examination revealed a reduced range of motion, particularly on the left and right lateral rotation. She also noted that strength and sensation was normal on the upper extremities.

On April 2, 1998 Dr. Stanton indicated that she treated appellant for chronic neck pain. On May 5, 1998 she diagnosed cervical spine syndrome, after noting a reduced range of neck motion on left lateral rotation and normal strength and sensation in the upper extremities.

On August 5, 1998 Dr. Mick indicated that appellant continued to experience neck pain following the work-related injury she sustained in September 1996. He stated that appellant had reached maximum medical improvement and that her pain and limitations would be permanent.

On September 2, 1998 Dr. Stanton diagnosed a cervical strain and thoracic outlet syndrome. She noted a limited range of motion on lateral rotation and tenderness of the left paraspinal muscles in the mid-cervical region. Dr. Stanton noted that MRI showed a bulging disc at the C5-6 level and that a cervical spine x-ray was normal. She recorded appellant's complaints of neck pain and stiffness, left arm pain and headaches. Dr. Stanton wrote "yes" to indicate that the present condition was due to the injury for which compensation was claimed. She concluded that appellant could not work more than one hour per day.

By decision dated October 15, 1998, the Office hearing representative found that the weight of the medical evidence, as represented by the opinion of Dr. Baumgaertner, indicated that appellant did not have any continuing condition causally related to the injury she sustained on September 18, 1996. The hearing representative stated that, although Drs. Stanton, Mick and Pierson related appellant's continuing condition to her accepted injury, they failed to provide any medical rationale to support their conclusions. In contrast, he found that Dr. Baumgaertner

noted the results of the diagnostic testing and based upon those results and his own clinical findings concluded that appellant's continuing condition was not related to the injury of September 18, 1996.

The Board finds that the Office did not meet its burden to terminate appellant's benefits effective December 10, 1997.

Once the Office accepts a claim, it has the burden of proving that the disability 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 federal employment, the Office may not terminate compensation without establishing that disability has ceased or that it is no longer related to employment.[2] Furthermore, the right to medical benefits for the accepted condition is not limited to the period of entitlement to disability.[3] To terminate authorization or medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition which no longer requires medical treatment.[4]

In the present case, Drs. Stanton, Mick and Pierson each provided medical opinions supporting that appellant continued to suffer residuals from her September 18, 1996 accepted injury of a cervical strain. Dr. Stanton, appellant's treating physician and a Board-certified family practitioner, submitted numerous attending physician's reports and other reports, in which she opined that appellant continued to suffered residuals of her accepted employment injury. Dr. Mick noted in his March 26, 1997 and August 5, 1998 reports that appellant continued to experience neck pain following the work-related injury she sustained in September 1996. On December 16, 1997 Dr. Pierson opined that appellant's injury was directly caused by the September 18, 1996 work incident.

On the other hand, Dr. Baumgaertner provided a medical opinion on August 28, 1997 and October 22, 1997 indicating that residuals of appellant's accepted injury had ceased. Based on the lack of any objective evidence supporting her current condition, Dr. Baumgaertner concluded that there was no correlation between appellant's 1996 injury and her present condition.

The Board finds that there is a conflict in the medical evidence under 5 U.S.C. § 8123 with respect to whether appellant continued to have an employment-related condition after December 10, 1997.[5] It is, as noted above, the Office's burden of proof to terminate compensation. Since an unresolved conflict in the evidence exists, the Board finds that the Office did not meet its burden in this case.

---

[1] *Frederick Justiniano*, 45 ECAB 491 (1994).

[2] *Id.*

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

[4] *Id.*

[5] Section 8123(a) provides that, when there is a disagreement between the physician making the examination for the United States and the physician of the employee, a third physician shall be appointed to make an examination to resolve the conflict; *see also Robert W. Blaine*, 42 ECAB 474 (1991).

The decision of the Office of Workers' Compensation Programs dated October 15, 1998 is reversed.

Dated, Washington, DC
September 25, 2000

David S. Gerson
Member

Willie T.C. Thomas
Member

Michael E. Groom
Alternate Member