U. S. DEPARTMENT OF LABOR

# Employees' Compensation Appeals Board

---

In the Matter of DARLENE R. KENNEDY and U.S. POSTAL SERVICE,
WEST PARK STATION, Philadelphia, PA

*Docket No. 02-1434; Submitted on the Record;*
*Issued November 20, 2002*

---

DECISION and ORDER

Before COLLEEN DUFFY KIKO, WILLIE T.C. THOMAS,
MICHAEL E. GROOM

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

On March 28, 2000 appellant, then a 41-year-old letter carrier, stated that, as she was getting mail from a mailbox, she felt a sharp pain on the left side of her hand and arm. She was restricted to light duty with no use of her left arm and no lifting over 10 pounds. Appellant stopped working on June 16, 2000 and filed a claim for recurrence of disability. The Office accepted appellant's claim for a shoulder sprain and cervical strain and began payment of temporary total disability compensation effective June 17, 2000. Appellant returned to light-duty work, four hours a day, on October 2, 2000. The Office paid compensation for the hours appellant did not work.

In a December 20, 2001 decision, the Office terminated appellant's compensation effective that date on the grounds that the medical evidence of record established that her employment-related disability had ceased as of that date. She requested reconsideration. In an April 2, 2002 merit decision, the Office denied appellant's request for modification of its prior decision.

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

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation benefits. 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.[1]

---

[1] *Jason C. Armstrong*, 40 ECAB 907 (1989).

In an April 7, 2000 report, Dr. Robert I. Winer, a Board-certified neurologist, gave a history of appellant's March 28, 2000 employment injury and stated that appellant had a full cervical range of motion with tenderness to palpation of the left cervical nerve root. He also noted that appellant had a full shoulder range of motion with tenderness to palpation of the left supraclavicular fossa. Dr. Winer indicated that appellant appeared to have a localized brachial plexus, lower cervical root-type pain. In a June 15, 2000 report, he indicated that nerve conduction study results were normal in absolute value but the left ulnar sensory study was prolonged in distal latency compared to the left median study on that side and the opposite ulnar sensory study. Dr. Winer also commented that stimulation across the brachial plexus revealed slight prolongation along the posterior cord bilaterally. He reported that an electromyogram (EMG) revealed evidence of mild chronic partial denervation in the hand muscles bilaterally. Dr. Winer concluded that the EMG and nerve conduction studies were consistent with lower cervical root dysfunction in a C8-T1 distribution as seen in the brachial plexus impingement.

The employing establishment referred appellant to Dr. Norman B. Stempler, an ostepath, for an examination. In a June 21, 2000 report, he diagnosed left trapezius strain and peritendinitis of the left shoulder, resolving. Dr. Stempler stated that, on examination, appellant had no objective evidence of a true radicular nature to her pain. He noted that appellant reported tenderness over the left side of the neck, cervical spine and anterior shoulder area. Dr. Stempler concluded that appellant would be able to return to full functional capacity within four to six weeks of the examination.

In a July 11, 2000 report, Dr. David Tabby, an osteopath, stated that appellant had decreased range of motion in the left shoulder in external and internal rotation. He noted that sensation was impaired to temperature and vibration in the left small finger. Dr. Tabby found tenderness of the left ulnar nerve at the elbow. He diagnosed left brachial plexopathy from chronic compression.

In a July 14, 2000 report, Dr. Philip S. Yussen, a Board-certified radiologist, stated that a magnetic resonance imaging (MRI) scan of the left shoulder showed mild to moderate supraspinatus tendinitis without definite evidence for a superimposed tear and degenerative changes of the superior glenoid labrum. He indicated that a tear in this region could not be excluded. In a July 24, 2000 report, Dr. Alan U. Glazer stated that an MRI scan of the cervical region showed torticollis convex to the left possibly secondary to positioning or a spasm and a questionable subtle disc bulging at C4-5. He found no disc herniation.

In an August 23, 2000 report, Dr. Tabby noted that appellant's MRI scans showed C4-5 disc degeneration, supraspinatus tendinitis and superior glenoid degeneration. He diagnosed left brachial plexopathy from chronic compression and rotator cuff pathology, consisting of supraspinatus tendinitis and superior glenoid degeneration, which he related to chronic trauma. In a September 26, 2000 report, Dr. Tabby stated that appellant was unable to carry a mailbag. He related her condition to her employment.

The Office referred appellant, together with a statement of accepted facts and the case record, to Dr. Richard J. Mandel, a Board-certified orthopedic surgeon, for an examination and second opinion. In an October 16, 2000 report, Dr. Mandel diagnosed a resolved strain and sprain of the left shoulder and residual deconditioning. He stated that there was no evidence of

any neurologic injury and considered the EMG results not to be significant, given the minimal findings on EMG testing. Dr. Mandel indicated that appellant could return to a sedentary or light-duty position for a month for conditioning followed by a return to her regular full duties. He concluded that appellant was fully recovered from the accepted work injury.

The employing establishment again referred appellant to Dr. Stempler. In a February 6, 2001 report, he diagnosed chronic refractory peritendinitis or bursitis of the left shoulder, a small rotator cuff tear of the left shoulder and brachial plexopathy of the left arm. Dr. Stempler stated that appellant continued to have symptoms of chronic left shoulder and left arm radicular-type pain.

The Office found a conflict in medical opinion between Dr. Tabby and Dr. Mandel. Appellant was referred, together with a statement of accepted facts and the case record, to Dr. Thomas C. Peff, a Board-certified orthopedic surgeon, selected as the impartial medical specialist. In a February 22, 2001 report, Dr. Peff stated that appellant had a passive full range of motion of both shoulders but, when asked to actively abduct the shoulder, complained of pain at about 40 degrees. He indicated that he found no evidence of glenohumeral instability and no cervical tenderness. Dr. Peff commented that the records showed that appellant sustained a left shoulder and cervical strain as a result of her work activity. He stated that appellant's soft tissue injury had resolved and concluded that she could return to work full time. Dr. Peff indicated that there was no significant neurological involvement based on the minimal findings of the EMG and her physical examination.

In a December 19, 2001 report, Dr. Tabby stated that he disagreed with Dr. Peff's report that appellant had a full range of motion of the left shoulder. He found appellant's range of motion to be restricted. He noted that Dr. Peff did not conduct a sensory examination. Dr. Tabby disagreed that appellant only sustained a soft tissue injury. He stated that appellant had ongoing pathology in her left brachial plexus and both rotator cuffs that would continue to be exacerbated by repetitive trauma.

The Office accepted appellant's claim for left shoulder sprain and cervical strain only. The Office did not accept that appellant had a brachial plexopathy, tendinitis of the shoulder or a rotator cuff tear as a result of the March 28, 2000 employment injury. Dr. Peff, acting as the impartial medical specialist, found that appellant's injuries were related to the March 28, 2000 employment injury. He pointed out the minimal findings of the EMG and the lack of other findings supported his conclusion that the effects of the injury had resolved. In situations when there exists opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[2] Dr. Peff presented a concise, well-reasoned report, based on an accurate medical history. His report, therefore, is entitled to special weight and, in the circumstances of this case, constitutes the weight of the medical evidence. Dr. Peff's report provides sufficient support for the Office's decision to terminate appellant's compensation.

[2] *James P. Roberts*, 31 ECAB 1010 (1980).

Drs. Stempler and Tabby diagnosed brachial plexopathy. Dr. Stempler also stated that appellant had a rotator cuff tear. The MRI scan of the shoulder showed tendinitis and glenohumeral deterioration. Dr. Tabby related appellant's condition to chronic irritation due to repetitive motion of the shoulder at work. However, neither Dr. Tabby nor Dr. Stempler explained how appellant's March 28, 2000 employment injury or his repetitive motion at work would have caused appellant's shoulder symptoms. Their reports, therefore, have limited probative value and are insufficient to show that the conditions they diagnosed were causally related to appellant's employment.

The decisions of the Office of Workers' Compensation Programs dated April 2, 2002 and December 20, 2001 are hereby affirmed.

Dated, Washington, DC
November 20, 2002

Colleen Duffy Kiko
Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member