U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ANDERSON L. CLARK and U.S. POSTAL SERVICE,
POST OFFICE, Tampa, FL

Docket No. 03-1009; Submitted on the Record;
Issued July 15, 2003

DECISION and ORDER

Before ALEC J. KOROMILAS, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issue is whether the Office of Workers' Compensation Programs met its burden of proof to terminate appellant's wage-loss compensation effective September 6, 2002.

On June 6, 1989 appellant, then a 43-year-old mail processor, filed a notice of occupational disease and claim for compensation (Form CA-2), alleging that he sustained lower back pain, lower left lumbar pain and hip pain due to his federal employment. The claim was accepted for low back strain and later for herniated nucleus pulposus at L3-4, L4-5 and L5-S1. Appellant had a history of nonindustrial back injuries including a motor vehicle accident in 1973 that left his lower left leg one and one half inches shorter than his right leg. Appellant also had some deformities in his feet. Appellant retired on medical disability on October 2, 1990. In a June 11, 1997 decision, the Office terminated appellant's compensation finding his work-related disability had ceased. In an April 1, 1998 decision, the Board reversed the Office decision to terminate appellant's compensation finding the medical reports from Dr. Victor Bilotta inconsistent and unrationalized.[1]

In a May 4, 2000 report, appellant's treating physician, Dr. James West, an orthopedist, wrote that appellant had restricted lumbar motion with lateral bending and forward flexion and pain on hyperextension. A straight leg raising test was mildly positive on the right at the extreme and on the left at 60 degrees. Appellant presented with complaints of weakness in the left lower extremity, spotty alteration of sensation and difficulty walking more than a block or two. He noted that appellant has a diagnosis of herniated nucleus pulposus of the lumbosacral spine of significant degree and he suspected some degree of spinal stenosis.

In an April 24, 2001 report, Dr. West wrote that appellant was experiencing increased back problems with pain radiating into his left hip. He indicated that appellant had trouble walking more than a block and standing for any length of time. Appellant was being treated with

[1] Docket No. 98-75 (issued April 1, 1998).

Extra Strength Tylenol and ice and heat. On examination he found appellant with limited motion of the lumbar spine, limited lateral bending forward flexion and hyperextension and sensitive to palpation. He found straight leg raising on the right positive at 70 to 80 degrees and on the left at 60 degrees. A magnetic resonance imaging (MRI) scan completed on May 8, 2001 revealed spinal stenosis throughout appellant's mid and lower lumbar spine.

In a March 26, 2002 letter, the Office referred appellant to Dr. Joseph Sena, a Board-certified orthopedist, for a second opinion. The Office also sent Dr. Sena, along with appellant's medical records, a statement of accepted facts, his date-of-injury job description and the results of three postal investigations of appellant. The materials from the investigation included a video of appellant riding a bike, walking regularly, washing his car, digging holes with a shovel, cutting branches with a handsaw and loading large branches into a vehicle. The investigations had been done in 1993, 1996 and 2002.

In a May 1, 2002 report, Dr. Sena wrote that he reviewed appellant's medical records and test results that revealed nonsurgical herniated discs at L2-3, L3-4, L4-5, spinal stenosis and degenerative disc disease consistent with his age. He indicated that appellant presented with low back pain radiating into both legs but had a good range of back motion with some pain on extreme flexion of the low back. He found no tenderness to palpation or hip pain. His straight leg raising test was normal, bilaterally, when seated; but yielded complaints of pain, hip and knee when lying down. His knee and hip flexors were normal.

Dr. Sena concluded:

> "In my opinion [appellant] is not disabled from employment. He currently is able to work on a full-time basis. He is currently able to work as a mail processor … can return to medium work duties on an eight-hour day…. This had clearly been demonstrated in the videotapes as well as review of his medical records and physical examination. I see no reason whatsoever why [appellant] cannot return to full-time work duties. In light of the fact, however, that [appellant] has been out of work for many years, *i.e.*; since the accident of 1989, I would anticipate that [appellant] would be very annoyed with returning and would anticipate complaints of discomfort…. He is currently able to sit, walk and stand for eight hours a day. I do not believe there is any contraindication for this patient to return to work as a mail carrier…."

Dr. Sena provided work restrictions that included no twisting for more than four hours a day.

In an August 5, 2002 letter, the Office proposed terminating appellant's wage-loss compensation based on the report of Dr. Sena. In an August 14, 2002 letter, appellant noted that he had good and bad days but he never knew what type of day he would have. Appellant indicated that he had been advised by his doctors to walk and attempt to be active. He further noted that part of Dr. Sena's reports was dated April 29, 2002 prior to the May 2, 2002 examination.

In a September 6, 2002 decision, the Office finalized the proposed termination. In a September 15, 2002 letter, appellant requested a review of the written record. In an October 22,

2002 letter, appellant reiterated his previous arguments that he had both good days and bad, was never sure what kind of day it would be, and that his doctors had told him to exercise.

Appellant also submitted a report from Dr. West who noted that he examined appellant on October 22, 2002, after not seeing him since April 24, 2001. Dr. West wrote that appellant has intermittent episodes of increased disability with his lower back that often result in him being bedridden. He indicated that appellant presented with complaints of back pain, though he was not experiencing a flare up at the time of the examination. Appellant told Dr. West that he was limited to bed rest for most of August due to a flare up of back pain and take Naprosyn and Aleve for the pain. He added that appellant was totally disabled due to his work-related back injury in 1989 and was awarded total disability by the Veterans Administration for medical problems related to his duty in Vietnam. On examination appellant was able to walk and get on and off the examining table with little difficulty. He had no intense muscle spasms, no fasciculations, but had increased pain from hyperextension. Appellant could toe heel walk and the straight leg test was positive on the left at 45 to 50 degrees and 60 to 70 degrees on the right and complained of pain over the lumbar spine upon heavy palpation. Dr. West interpreted an MRI scan as showing a moderate spine herniation at L2-3 with moderate to severe central spinal stenosis, small central disc herniation at L3-4 with moderate spinal stenosis, a small to moderate size central disc herniation at L4-5 with central spinal stenosis and diffuse central disc bulging at L1-2.

In a February 3, 2003 decision, the Office of Branch and Hearings Review affirmed the September 6, 2002 termination relying on the report of Dr. Sena noting that the report date of April 29, 2002 was corrected to reflect the date of the examination.

The Board finds that the Office did not meet its burden of proof in terminating appellant's wage-loss compensation effective September 6, 2002 due to a conflict in the medical evidence.

Under the Federal Employees' Compensation Act,[2] once the Office has accepted a claim it has the burden of justifying termination or modification of compensation benefits.[3] The Office may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.[4] The Office's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[5]

In the present case, the Office relied on the May 1, 2002 report of Dr. Sena, a second opinion referral physician. However, Dr. Sena's report is not well rationalized. Dr. Sena found nonsurgical herniated discs at L2-3, L3-4, L4-5, and explained that these were consistent with age and questions whether they were work related; even though the statement of accepted facts

[2] 5 U.S.C. §§ 8101-8193.

[3] *Charles E. Minniss,* 40 ECAB 708, 716 (1989); *Vivien L. Minor,* 37 ECAB 541, 546 (1986).

[4] *Id.*

[5] *See Del K. Rykert,* 40 ECAB 284, 295-96 (1988).

required that he accept that herniated discs as work related and base his medical opinion on that fact. Furthermore, Dr. Sena opines that appellant's condition improved, yet he never explains why. He concludes that appellant is not disabled without discussing the significance of his objective findings, such as appellant's herniated discs and spinal stenosis or why, if he found appellant without a disability, he provided work restrictions.

The reports of Dr. West, though clearly stating appellant was totally disabled, lack sufficient rationalization. They do not discuss objective findings such as the results of the MRI scan. Additionally, Dr. West also does not discuss the impact of appellant's preexisting injuries on his work-related disability, such as the motor vehicle accident that left appellant's left leg one and a half inches shorter than his right.

The decisions of the Office of Workers' Compensation Programs dated February 3, 2003 and September 6, 2002 are reversed.

Dated, Washington, DC
July 15, 2003

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member