

On September 4, 2001 appellant, then a 43-year-old paralegal specialist, filed a traumatic injury claim alleging that on August 31, 2001 she experienced a headache and severe pain on the left side of her neck and in her shoulder and low back as a result of moving boxes from

underneath a desk. By letter dated January 25, 2002, the Office accepted her claim for a cervical strain.

On July 1, 2002 appellant was treated by Dr. Hampton J. Jackson, a Board-certified orthopedic surgeon. In a report of that date, Dr. Jackson found that appellant sustained a mild ligamentous injury to the cervicodorsal spine as a result of the August 31, 2001 employment injury. He stated that a cervical disc injury due to the accepted employment injury should be ruled out with a magnetic resonance imaging (MRI) scan and possibly a discogram. He prescribed a home cervical traction unit, a moist heating pad and electromyogram (EMG) and nerve conduction study.

A July 16, 2002 MRI scan report from Dr. Howard A. Sachs, a Board-certified radiologist, found a small left paracentral posterior disc herniation at C4-5 which caused some mild flattening of the left anterior contour of the cord. At C4-6 and C6-7, Dr. Sachs also found degenerative disc disease and a bulging disc posteriorly. At C6-7, he reported some mild flattening of the anterior aspect of the thecal sac and a small opacity in the left anterolateral recess which he was not sure whether it was a bone spur or a small subannular disc herniation. Dr. Sachs further reported signs of some narrowing of the left neural foramen due to uncinate process bony hypertrophic changes.

An EMG and nerve conduction study report dated December 26, 2002 from Dr. Daniel R. Ignacio, a Board-certified physiatrist, found prolonged distal sensory latency of the left median nerve, normal nerve conduction study across the right and left brachial plexus with normal median F-wave latency and abnormal electrodiagnostic EMG findings with evidence of denervation in selected muscles of the right and left upper limbs including the arms, shoulders and the right and left cervical paraspinal muscles along the C6 and C7 distribution. The report contained a diagnosis of cervical disc syndrome and cervical radiculopathy and concluded that the EMG findings were consistent with cervical denervation. In a December 26, 2002 report, Dr. Jackson found that the EMG study was consistent with left C7 and bilateral C6 radiculopathy and left carpal tunnel syndrome.

In progress notes and disability certificates covering intermittent dates from July 22, 2002 to May 6, 2003, Dr. Jackson found that appellant was either totally disabled due to her employment-related neck symptoms or capable of performing limited-duty work. In a January 15, 2003 progress note, Dr. Jackson utilized the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*) and found that appellant had a 25 percent permanent impairment of the right upper extremity secondary to C6 radiculopathy and a 40 percent permanent impairment of the left upper extremity which caused radiculopathy at C6 and C7.

By letter dated April 10, 2003, the Office referred appellant, together with a statement of accepted facts, the case record and a list of questions, to Dr. Robert A. Smith, a Board-certified orthopedic surgeon, for a second opinion medical examination. In an April 24, 2003 report, Dr. Smith provided a history of appellant's August 31, 2001 employment injury and medical treatment. On physical examination of her neck, he reported diffuse subjective tenderness, but found no spasm, atrophy, trigger points or deformity. He stated that appellant experienced pain when she was asked to move her neck in a normal way in different planes and that she limited

her range of motion. Dr. Smith noted that palpation of the neck during motion revealed no spasm, crepitation or rigidity. A neurological examination of the upper extremities was completely normal with no finding of focal motor, sensory or reflex deficit. Dr. Smith diagnosed a resolved cervical strain. He indicated that the actual MRI scan results were unavailable for review but stated that he reviewed the report which found herniations at multiple levels consistent with degenerative disc disease and what appeared to be protrusions. Dr. Smith opined that it was unlikely that these findings were related to the August 31, 2001 employment injury. In addition, he stated that there appeared to be a poor correlation between the multiple findings on the EMG study, as appellant had a normal neurologic examination and had no history of radiating pain into her extremities based on her first visit with Dr. Jackson. Dr. Smith opined that these findings were also unrelated to the accepted employment injury which was confirmed by his essentially normal examination. He related that a soft tissue strain was the correct diagnosis and explained that a cervical strain resolves within six to eight weeks with or without treatment.

Dr. Smith found that appellant did not appear to have any chronic soft tissue condition related to the August 31, 2001 employment injury and, therefore, her cervical strain had resolved. He stated that it was unlikely that the MRI scan and EMG diagnoses were related to the accepted employment injury because appellant never complained about any radiating pain to Dr. Jackson when she first saw him and his initial diagnosis was a mild soft tissue strain. Dr. Smith believed the MRI scan findings were incidental and degenerative in nature and unrelated to the accepted employment injury. He concluded that, based on the lack of an initial complaint of radiating pain into the extremities and Dr. Jackson's and his normal neurologic findings, it was unlikely that the reported EMG findings had any clinical significance or were related to the August 31, 2001 employment injury.

Utilizing the A.M.A., *Guides*, Dr. Jackson opined that appellant had a zero percent permanent impairment of either upper extremity based on his essentially normal objective examination. He found that she reached maximum medical improvement on October 31, 2001 and he did not see any objective evidence to support work restrictions. Dr. Smith concluded that appellant was not disabled from her work duties. In an April 14, 2002 work capacity evaluation, Dr. Smith stated that appellant could perform her usual job eight hours a day with no physical limitations.

In a May 9, 2003 letter, appellant's attorney expressed disagreement with Dr. Smith's report, contending that Dr. Smith failed to conduct a thorough medical examination and stated that no tests were performed. He further stated that appellant told Dr. Smith about her extreme pain and other symptoms but he overlooked her condition. Counsel argued that Dr. Smith's report contradicted Dr. Jackson's prior examinations as he found no impairment and no permanent disability, work restrictions or limitations.

The Office received Dr. Jackson's disability certificates and progress notes which found that appellant was totally disabled on April 28 and May 5 and 6, 2003 and that she was partially disabled from May 7 through June 4, 2003.

By letter dated June 16, 2003, the Office issued a notice of proposed termination of appellant's compensation based on Dr. Smith's April 24, 2003 medical report. The Office stated

that Dr. Smith's report supported a finding that appellant no longer had any disability causally related to the August 31, 2001 employment injury. The Office provided 30 days in which appellant could respond to this notice.

The Office received Dr. Jackson's disability certificates which indicated that appellant was totally disabled from June 20 through 24 and July 2 through 7, 2003.

By letter dated July 13, 2003, appellant, through her attorney, submitted Dr. Jackson's July 7, 2003 progress note which indicated that she experienced neck pain and that she could only perform limited-duty work four hours a day. She also submitted Dr. Jackson's July 27, 2003 disability certificate and July 28, 2003 progress note which found that she was totally disabled on July 21, 24 and 28, 2003 and that beginning July 29, 2003, she could work four hours a day.

By decision dated August 11, 2003, the Office terminated appellant's compensation effective August 9, 2003. The Office found the evidence submitted by appellant insufficient to establish that she was totally disabled for work and accorded weight to Dr. Smith's medical report.

Following the issuance of the Office's August 11, 2003 decision, the Office received Dr. Jackson's August 25, 2003 report. Dr. Jackson opined that appellant's current condition, a herniated cervical disc at C4-5 and at C6-7 was caused by the accepted employment injury. He stated that this condition was nothing more than a sequel or continuation of the disc injury appellant sustained on August 31, 2001. Dr. Jackson further stated that her part-time work and physical restrictions were permanent and that without surgery she had reached maximum medical improvement.

In a September 22, 2003 progress note, Dr. Jackson indicated that appellant suffered from significant leg symptoms but stated that she could continue to perform limited-duty work as he did not find any worsening condition on physical examination.

By letter dated October 22, 2003, appellant, through counsel, requested reconsideration of the Office's August 11, 2003 decision. Counsel argued that Dr. Smith's April 24, 2003 report was not sufficient to terminate appellant's compensation. He further argued that the medical evidence was sufficient to establish that she continued to have residuals and disability due to the August 31, 2001 employment injury.

On November 25, 2003 the Office issued a decision, denying modification of the August 11, 2003 decision. The Office found the evidence submitted by appellant insufficient to establish that she had any continuing residuals or disability causally related to her August 31, 2001 employment injury.

Subsequently, appellant submitted Dr. Jackson's December 15, 2003 progress note in which he recommended that she undergo another MRI scan based on her lower back and lower extremities symptoms. Dr. Jackson stated that she was still restricted to working four hours a day. In a January 12, 2004 progress note, he found that appellant sustained a severe injury as a result of the August 31, 2001 employment injury. He indicated that she was being closely

monitored for any progressive neurological change in her lower back and lower extremities and that she could only work four hours a day.

In a June 2, 2004 letter, appellant, through her attorney, requested reconsideration of the Office's November 25, 2003 decision. She submitted medical records previously of record and considered by the Office. She also submitted Dr. Jackson's progress notes dated February 16 to September 13, 2004, which found that she continued to experience symptoms causally related to the August 31, 2001 employment injury and that she could only work four hours a day. In the September 13, 2004 progress note, Dr. Jackson found that appellant was totally disabled for work until her neck condition improved.

By decision dated November 1, 2004, the Office again denied modification of the November 25, 2003 decision, finding that the evidence submitted was insufficient to establish that she had any continuing residuals or disability due to the August 31, 2001 employment injury.

LEGAL PRECEDENT

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation. After it has been determined that an employee has disability causally related to her employment, the Office may not terminate compensation without establishing that the disability had ceased or that it was no longer related to the employment.¹ The Office's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.² If the Office, however, meets its burden of proof and properly terminates compensation, the burden for reinstating compensation benefits properly shifts to appellant.³ To prevail appellant must establish by the weight of the reliable, probative and substantial evidence that he or she had an employment-related disability, which continued after termination of compensation benefits.⁴

The Federal Employees' Compensation Act provides that, if there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.⁵ The implementing regulation states that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an Office medical adviser or consultant, the Office shall appoint a third physician to make an examination.

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

² *See Del K. Rykert*, 40 ECAB 284, 295-96 (1988).

³ *See Virginia Davis-Banks*, 44 ECAB 389 (1993); *Joseph M. Campbell*, 34 ECAB 1389 (1983).

⁴ *Talmadge Miller*, 47 ECAB 673, 679 (1996); *see also George Servetas*, 43 ECAB 424 (1992).

⁵ 5 U.S.C. §§ 8101-8193, 8123.

This is called a referee examination and the Office will select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case.⁶

ANALYSIS

The Office accepted that appellant sustained a cervical strain following her August 31, 2001 employment injury. Appellant received compensation for partial disability based on her ability to work four hours a day due to her neck condition as set forth by her treating physician, Dr. Jackson. The Office subsequently terminated appellant's compensation, finding that she no longer had any residuals or disability causally related to the accepted employment injury based on the April 24, 2003 medical report of Dr. Smith, an Office referral physician, who reported normal findings on physical, neurological and objective examination. He diagnosed a resolved cervical strain. Dr. Smith opined that it was unlikely that MRI scan findings of herniations at multiple levels consistent with degenerative disc disease and protrusions and EMG/nerve conduction study diagnoses of cervical disc syndrome, cervical radiculopathy and cervical denervation were related to the August 31, 2001 employment injury. He stated that the MRI scan findings were incidental and degenerative in nature and that the EMG findings had no clinical significance. Dr. Smith further opined that appellant had no permanent impairment of either upper extremity based on the A.M.A., *Guides*. He concluded that she was not disabled from performing her usual work duties and that she could work eight hours a day with no physical restrictions.

Dr. Jackson opined that she continued to have residuals and disability due to the August 31, 2001 employment injury. The Board finds a conflict between Dr. Smith and Dr. Jackson with regard to the issue of whether appellant has any continuing residuals or disability causally related to the August 31, 2001 employment injury. As an unresolved medical conflict existed at the time the Office terminated benefits, the Office did not meet its burden of proof in terminating appellant's compensation benefits.

CONCLUSION

The Board finds that the Office improperly terminated appellant's compensation effective August 9, 2003 because a conflict exists in medical opinion evidence as to whether she has any continuing residuals or disability causally related to the August 31, 2001 employment injury.

⁶ 20 C.F.R. § 10.321.

ORDER

IT IS HEREBY ORDERED THAT the November 1, 2004 decision of the Office of Workers' Compensation Programs is reversed.

Issued: January 19, 2006
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board