United States Department of Labor
Employees' Compensation Appeals Board

M.I., Appellant	)	
and	)	**Docket No. 11-1649**
	)	**Issued: March 6, 2012**
DEPARTMENT OF HEALTH & HUMAN SERVICES, SOCIAL SECURITY ADMINISTRATION, Port Huron, MI, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 6, 2011 appellant filed a timely appeal from a March 10, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether OWCP met its burden of proof to terminate appellant's compensation benefits effective November 24, 2009 on the grounds that she had recovered with no disability from a February 21, 2008 employment injury; and (2) whether appellant established that she had any continuing employment-related disability or condition after November 24, 2009 due to her accepted conditions.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On February 25, 2008 appellant, then a 36-year-old claims representative, filed a traumatic injury claim, alleging that she injured her left lower extremity when she slipped on black ice on February 21, 2008 when she was entering her car to go home from work. She stopped work on March 21, 2008 and did not return. On May 5, 2008 OWCP accepted that appellant sustained employment-related sprains of the left knee, lumbar region of the back and second digit of the left hand.

A March 4, 2008 x-ray of the left knee was normal. An April 25, 2008 magnetic resonance imaging (MRI) scan of the left knee demonstrated osteoarthritis and findings that could represent a Baker's or ganglion cyst. In a June 12, 2008 report, Dr. Nick Reina, a Board-certified physiatrist, noted the history of injury and appellant's complaints of constant pain in the tail area radiating into the left cheek or hip area, constant left knee pain radiating into the foot, constant pain and numbness in fingers two through four of the left hand and constant pain in the back of the neck. He provided physical examination findings, noting that she was morbidly obese with slightly limited neck and shoulder range of motion and a negative straight-leg raising. Dr. Reina diagnosed neck, left knee, left hand/fingers and low back pain. On June 17, 2008 Dr. D. David Ernst, a Board-certified osteopath specializing in orthopedic surgery, provided examination findings and diagnosed left knee pain, chondromalacia patella of the left knee and minimal degenerative osteoarthritis of the left knee.

A June 25, 2008 MRI scan study of the lumbar spine showed minimal circumferential bulging of the intervertebral disc at L4-5 and was otherwise negative. A June 25, 2008 MRI scan study of the cervical spine demonstrated minimal posterior bulging of the intervertebral disc at C6-7 and was otherwise negative. On July 1, 2008 Dr. Reina advised that he had discussed the bulges found in the cervical and lumbar area and that they could have been present prior to the fall but were made symptomatic by the fall. He submitted additional reports which noted appellant's complaint of neck and low back pain. On October 3, 2008 Dr. Reina advised that she could not return to work. On October 30, 2008 he stated that he was at a loss to explain why appellant was actually getting worse with therapy and medication. On November 7, 2008 it was recommended that appellant get a second opinion. She was placed on the periodic compensation rolls. In November 2008, OWCP referred appellant to Dr. Bruce D. Abrams, a Board-certified orthopedic surgeon, for a second-opinion evaluation. In a December 2, 2008 report, Dr. Abrams noted his review of the statement of accepted facts and medical record. He described the history of injury and appellant's complaints of left hand numbness in the first web space along the index finger and pain on the left side of her neck, mid portion of the upper back between the shoulders, top of the left shoulder and in the lower back with radiation into the left upper buttock. Dr. Abrams found that examination of the cervical and lumbar regions, left knee and left hand were normal and that she was neurologically intact. He diagnosed left knee contusion/sprain, resolved, with normal examination; lumbar sprain, resolved, with normal neurologic and physical examinations and sprain of second digit of the left hand, resolved, with normal examination. Dr. Abrams advised that appellant's complaints were subjective in nature and indicated that her employment injuries had resolved. In an attached work capacity evaluation, he advised that she could return to full-time work without restrictions.

By report dated December 15, 2008, Dr. E. Neil Pasia, a Board-certified osteopath specializing in orthopedic surgery, stated that appellant fell in February and had pain in her neck and low back and arm and leg numbness. He reviewed diagnostic studies and provided physical examination findings and diagnosed neck and low back pain and myofascial strain, noting that her imaging findings were fairly mild despite her significant symptoms. Dr. Pasia recommended chronic pain management. On January 23, 2009 Dr. Reina noted that appellant felt discomfort with sitting for any extended period of time and recommended a functional capacity evaluation. On a January 23, 2009 work capacity evaluation, he advised that she could work one to two hours daily with a five-pound limitation. In a February 10, 2009 report, Dr. Reina noted that appellant's back pain was in the sacrum or coccyx area and that she had left foot numbness that began on the great toe. Spine range of motion was diminished. Dr. Reina stated that appellant's pain problems were beyond "my scope or ability to resolve," and referred her to Dr. Pasia. A February 10, 2009 x-ray of the sacrum and coccyx was unremarkable.

OWCP determined that a conflict of medical opinion arose between Dr. Reina and Dr. Abrams regarding whether appellant had any continuing disability causally related to the February 21, 2008 employment injury, the extent of the employment-related injury, the degree of disability associated with the work injury and the physical limitations/restrictions imposed by the employment injury. On March 16, 2009 it referred appellant to Dr. Zachary J. Endress, a Board-certified orthopedic surgeon, for an impartial evaluation.

In a March 30, 2009 report, Dr. Endress noted his review of the statement of accepted facts and medical record and described the history of injury and appellant's complaint of neck and low back pain. He advised that no abnormality was demonstrated on examination of the cervical spine, which had a normal appearance with no torticollis or wry neck deformity. Cervical spine range of motion was essentially full, including lateral rotation, lateral flexion, forward flexion and extension. Foraminal closure test was negative. Neurologic testing of both upper extremities including motor, sensory and deep tendon reflexes, was intact and there was no atrophy of the shoulder girdle, arm, forearm or hand musculature. Dr. Endress indicated that left hand examination also demonstrated no abnormality. He stated that the left hand was normal in appearance with no swelling or deformity and that appellant could clench a tight fist and could straighten her fingers. Examination of appellant left knee revealed a normal appearance with no swelling or deformity. Dr. Endress reported that she walked with a normal gait and was able to get up and down from the examining table without difficulty or assistance. Lumbosacral spine examination revealed tenderness over the sacral coccygeal junction, which extended all the way up through the presacral area and into the lower lumbar region. The sciatic notches were nontender and straight leg raising was negative bilaterally. Patrick's test was negative and neurologic testing of both lower extremities, including motor, sensory and deep tendon reflexes, was intact. Dr. Endress advised that appellant had recovered from the injuries she sustained in her slip and fall injury of February 21, 2008 and stated that there were no objective physical findings to corroborate her complaints of pain in the coccygeal area. He opined that she could return to work as a claims representative, and that he would not place any restrictions on work or recreational activities. In an attached work capacity evaluation, Dr. Endress advised that appellant could work eight hours a day without restriction.

On April 17, 2009 OWCP proposed to terminate appellant's compensation benefits on the grounds that the medical evidence established that her work-related conditions had resolved.

On May 5, 2009 Dr. Endress recommended an MRI scan study of the sacrococcygeal junction, which was authorized by OWCP. By letter dated May 13, 2009, appellant disagreed with the proposed termination, asserting that she had also injured her neck on February 21, 2008 and that her condition had worsened. She continued to have constant neck and back pain and that Dr. Endress' report did not agree with what he told her at the time of his examination. Appellant indicated that she called his office and also reported that Dr. Abrams did not perform a thorough examination.

In a May 13, 2009 report, Dr. Cheryl A. Skarbo, a chiropractor, advised that appellant had been seen since January 7, 2009 for neck, lower back and left leg pain and numbness. She stated that she had performed adjustments with some relief but that appellant's condition had progressively worsened. A July 11, 2009 MRI scan of the sacrum demonstrated a possible unfused joint between the first and second coccygeal segments and no evidence of occult bone trauma to the sacrum or coccyx.

By report dated July 17, 2009, Dr. Endress noted that he had reviewed the July 11, 2009 MRI scan study and reported that it did not show any abnormality that would explain appellant's persistent complaint of pain in the tailbone area. He reiterated that she could return to her usual work as a claims representative. In an August 28, 2009 report, Dr. Reina indicated that appellant was seen for neck and low back pain and that he had last seen her in March 2009. He reviewed her medication regimen and an x-ray of the pelvis, stating that the pubis symphysis was slightly displaced, most likely representing a little rotation of the pelvis when the x-ray was done.

By decision dated November 24, 2009, OWCP found that the weight of the medical evidence rested with the opinion of Dr. Endress who performed the referee examination and finalized the termination of benefits.

On December 1, 2009 appellant requested reconsideration, asserting that the injuries of February 21, 2009 had not resolved and that she was in constant pain. In a November 18, 2009 report, Charles Regan, a physician's assistant, provided examination findings and diagnosed neck pain likely due to a C6-7 bulging disc with radiculopathy of the left upper extremity, low back pain related to an L4-5 bulging disc with radiculopathy, sciatica and coccydynia secondary to unfused coccyx. A November 18, 2009 x-ray of the lumbar spine was normal.

On a December 1, 2009 form report, Dr. Skarbo noted that appellant had complaints of difficulty walking, headaches and low back, leg and neck pain due to a fall. She diagnosed subluxations of C5 and L5, lumbalgia, sciatica, muscle spasms and cervicalgia and recommended corrective care. Dr. Skarbo also submitted very brief, form-type treatment notes dated November 13, 2007 to December 1, 2009 that were essentially illegible.

Dr. J. Alan Robertson, an orthopedic surgeon, provided a December 15, 2009 report. He described the history of injury and appellant's medical care and noted her complaints of headaches, limited neck range of motion, low back pain, left knee pain and foot numbness. Dr. Robertson performed physical examination and noted that she was depressed over her physical status and the chronicity of her pain with associated physical disability. His impression was that appellant was pathologically obese with equivocal left knee meniscal signs, equivocal left hip labral signs, weakness of the extensor hallucis longus and tibialis anterior on the left, had

absolutely no movement of the lower back secondary to pain and had a 50 percent reduction in neck motion secondary to pain, with equivocal Sperling's signs bilaterally. After reviewing cervical and lumbar MRI scan films, Dr. Robertson indicated that there was no evidence of a neurocompressive mass of the cervical spine and very early-stage desiccation at L4-5 with a high-intensity zone to the left of midline consistent with an acute annular tear which, in the axial plane, was represented by an eccentric protrusion or extrusion paracentrally to the left of midline effacing the thecal sac. He concluded that appellant had extreme restriction of musculoskeletal function and could not work. A December 28, 2009 MRI scan study of the left knee demonstrated focal chondromalacia patella, small knee joint effusion and a popliteal cyst.

In a merit decision dated February 11, 2010, OWCP denied modification of the November 24, 2009 decision.

Appellant was terminated by the employment establishment, effective June 18, 2010. She again requested reconsideration on October 14, 2010 and submitted reports from Dr. Robertson dated February 4 to July 22, 2010. Dr. Robertson diagnosed trauma to the low back with resultant disc joint disruption at L4-5 compressing upon the L5 nerve root on the left and producing radiculopathy; trauma to the left hip with resultant abnormal-appearing MRI scan study, labral tear could not be excluded and further investigation was required; polytrauma and fall on same level from slipping, tripping or stumbling at work. He reiterated that appellant could not work. A September 13, 2010 computerized tomography (CT) scan and discography of the lumbar spine demonstrated a concentric disc bulge and congenitally short pedicles at L4-5 with no canal stenosis or neural foraminal compromise. On October 14, 2010 Dr. Robertson noted his review of the September 13, 2010 studies, advising that they demonstrated an annular tear on the left at L4-5. In reports dated November 10, 2010 and February 16, 2011, he continued to advise that appellant's pain was unbearable and that she was totally disabled.

In a merit decision dated March 10, 2011, OWCP denied modification of the prior decisions.

LEGAL PRECEDENT -- ISSUE 1

Once OWCP accepts a claim and pays compensation, it has the burden of justifying modification or termination of an employee's benefits. OWCP may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.[2] OWCP's burden of proof in terminating compensation includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[3]

Section 8123(a) of FECA provides that if there is 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.[4] When the case is referred to an

[2] *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[3] *Id.*

[4] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[5]

ANALYSIS -- ISSUE 1

The Board finds that OWCP met its burden of proof to terminate appellant's compensation benefits effective November 24, 2009. The accepted conditions in this case are sprains of the left knee, lumbar region and second digit of the left hand. OWCP determined that a conflict in medical evidence had been created between the opinions of Dr. Reina, an attending physician and Dr. Abrams, an OWCP referral physician, regarding whether appellant had any continuing disability causally related to the February 21, 2008 employment injury, the extent of the employment-related injury, the degree of disability associated with the work injury, and the physical limitations/restrictions imposed by the employment injury. It then properly referred appellant to Dr. Endress, Board-certified in orthopedic surgery, for an impartial evaluation.

In a March 30, 2009 report, Dr. Endress noted his review of the statement of accepted facts and medical record. He described the history of injury and appellant's complaint of neck and low back pain and performed a thorough physical examination. Dr. Endress advised that no abnormality on cervical spine examination as it had a normal appearance with no torticollis or wry neck deformity and that the left hand was normal in appearance with no swelling or deformity. Appellant walked with a normal gait and was able to get up and down from the examining table without difficulty or assistance. While lumbosacral spine examination revealed tenderness over the sacralcoccygeal junction through the presacral area and into the lower lumbar region, the sciatic notches were nontender and straight leg raising was negative bilaterally. Patrick's test was negative and neurologic testing of both lower extremities, including motor, sensory and deep tendon reflexes, was intact. Dr. Endress advised that appellant had recovered from the accepted conditions caused by the February 21, 2008 employment injury, indicating that there were no objective physical findings to corroborate her complaints of pain in the coccygeal area. He concluded that she could return to her work for eight hours daily as a claims representative, with no restrictions to her physical activity. Dr. Endress reviewed a July 11, 2009 MRI scan study of the sacrum and on July 17, 2009, reported that the study did not show any abnormality that would explain appellant's persistent complaint of pain in the tailbone area. He reiterated that she could return to her usual employment as a claims representative.

The Board finds that Dr. Endress provided a comprehensive, well-rationalized opinion in which he clearly advised that any residuals of appellant's accepted conditions had resolved and that she could return to her preinjury position as a claims representative. Dr. Endress opinion is therefore entitled to the special weight accorded an impartial examiner and constitutes the weight of the medical evidence.[6]

[5] *Manuel Gill*, 52 ECAB 282 (2001).

[6] *See Sharyn D. Bannick*, 54 ECAB 537 (2003).

The medical evidence appellant submitted is insufficient to overcome the weight accorded Dr. Endress as an impartial medical specialist regarding whether she had residuals of her accepted conditions. In her May 13, 2009 report, Dr. Skarbo, a chiropractor, did not discuss the accepted conditions or explain why appellant could not perform her usual job.[7] In his August 28, 2009 report, Dr. Reina merely reported that appellant was seen for complaints of neck and low back pain and reviewed an x-ray of the pelvis. The Board has long held that reports from a physician who was on one side of a medical conflict that an impartial specialist resolved, are generally insufficient to overcome the weight accorded to the report of the impartial medical examiner or to create a new conflict.[8] Dr. Reina had been on one side of the conflict resolved by Dr. Endress. Furthermore, he did not discuss the accepted sprains and did not explain why they caused appellant's total disability.

The Board therefore concludes that Dr. Endress' opinion that appellant had recovered from the employment injury is entitled to the special weight accorded an impartial medical examiner,[9] and the additional medical evidence submitted is insufficient to overcome the weight accorded him as an impartial medical specialist regarding whether appellant had residuals of her accepted conditions. OWCP therefore properly terminated appellant's compensation benefits effective November 24, 2009.[10]

LEGAL PRECEDENT -- ISSUE 2

As OWCP met its burden of proof to terminate appellant's compensation benefits effective November 24, 2009, the burden shifted to her to establish that she had any continuing disability causally related to her accepted right upper extremity injury.[11] To establish a causal relationship between the condition, as well as any attendant disability claimed and the employment injury, an employee must submit rationalized medical evidence, based on a complete factual and medical background, supporting such a causal relationship.[12] Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[13] Rationalized medical evidence is medical evidence which includes a physician's rationalized medical opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated

[7] Under section 8101(2) of FECA, the term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist and subject to regulation by the Secretary. *D.S.*, Docket No. 09-860 (issued November 2, 2009). Dr. Skarbo's May 13, 2009 report did not include a diagnosis of subluxation. *See* discussion *infra* for later submitted reports from the chiropractor.

[8] *I.J.*, 59 ECAB 408 (2008).

[9] *See Sharyn D. Bannick, supra* note 6.

[10] *Manuel Gill, supra* note 5.

[11] *See Joseph A. Brown, Jr.*, 55 ECAB 542 (2004).

[12] *Jennifer Atkerson*, 55 ECAB 317 (2004).

[13] *Id*.

employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[14]

ANALYSIS -- ISSUE 2

The Board finds that appellant submitted insufficient medical evidence with her December 1, 2009 and October 14, 2010 reconsideration requests to establish that she continued to be disabled after November 24, 2009 due to the February 21, 2008 employment injury, accepted for left knee, low back and finger sprains.

The diagnostic studies are insufficient to meet appellant's burden as they contain no opinion as to the cause of the diagnosed conditions and medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[15] The report from Mr. Regan does not constitute competent medical evidence as a physician's assistant is not considered a physician under FECA.[16] While Dr. Skarbo submitted a form report in which she diagnosed subluxations at L5 and C5, she did not indicate that these were diagnosed by x-ray. She would therefore not be considered a physician under FECA.[17]

The Board finds the opinion of Dr. Robertson of diminished probative value as his reports do not contain sound medical reasoning establishing that appellant was totally disabled after November 24, 2009 due to the accepted conditions caused by the February 21, 2008 employment injury.[18] A medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale.[19] Dr. Robertson submitted a number of reports dated from December 15, 2009 to February 16, 2011 in which he described appellant's complaint of worsening pain and diagnosed trauma to the low back with resultant disc joint disruption at L4-5 compressing upon the L5 nerve root on the left and producing radiculopathy; trauma to the left hip with resultant abnormal-appearing MRI scan study in which a labral tear could not be excluded; and polytrauma. These conditions were not accepted as caused by the February 21, 2008 employment injury. Furthermore, Dr. Robertson did not explain the mechanics of how the February 21, 2008 employment injury, when appellant slipped and fell in the parking lot at work, caused continuing disability after November 24, 2009 due to the accepted sprains to the left knee, lumbar region and second digit of the left hand. As such, his opinion is entitled to little

[14] *Leslie C. Moore*, 52 ECAB 132 (2000); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[15] *Willie M. Miller*, 53 ECAB 697 (2002).

[16] *Ricky S. Storms*, 52 ECAB 349 (2001); *see* 5 U.S.C. § 8101(2).

[17] *Supra* note 7. The Board also notes that certain of Dr. Skarbo's chiropractic treatment preceded the February 21, 2008 employment injury.

[18] *Sandra D. Pruitt*, 57 ECAB 126 (2005).

[19] *T.M.*, Docket No. 08-975 (issued February 6, 2009).

probative value and is insufficient to meet an employee's burden of proof to establish that she continues to have work-related disability due to the accepted conditions.[20]

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that OWCP met its burden of proof to terminate appellant's compensation benefits effective November 24, 2009 on the grounds that she had no residuals of an accepted condition, and that she did not establish that she had any continuing employment-related disability or condition after that date causally related to the February 21, 2008 employment injury.

ORDER

IT IS HEREBY ORDERED THAT the March 10, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 6, 2012
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

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

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

[20] *S.S.*, 59 ECAB 315 (2008).