United States Department of Labor
Employees' Compensation Appeals Board

J.L., Appellant	)	
and	)	**Docket No. 13-304**
	)	**Issued: March 10, 2014**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Perry Point, MD, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 26, 2012 appellant, through her attorney, filed an appeal from an October 17, 2012 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 appellant established that modification of the May 18, 1989 wage-earning capacity determination is warranted; and (2) whether OWCP met its burden of proof to terminate appellant's compensation benefits as of July 1, 2013.

On appeal, appellant's attorney asserts that the decision is contrary to fact and law.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On January 31, 1980 appellant, then a 28-year-old nurse, sustained injury during a confrontation with a patient. OWCP accepted her claim for lumbar, cervical and thoracic sprains and lumbosacral neuritis. Appellant was disabled from February 4 through 11, 1980 and came under the care of Dr. Pierre L. LeRoy, a Board-certified neurosurgeon. She returned to duty on February 11, 1980 but could not continue to work and was disabled through March 22, 1980. Appellant worked on an intermittent basis at the employing establishment from March 24 through July 2, 1980. Beginning on June 9, 1981 she began work as an office nurse in private practice and worked through November 1983, when she went to work for a different physician through July 1984. From July through November 1984, appellant worked at the Delaware State Hospital in supervisory positions but returned to the private sector.

The record reflects that appellant underwent diagnostic testing on July 12, 1985 by Dr. Alan B. Evantash, a Board-certified radiologist. The cervical spine showed vertebral body heights and disc spaces normally maintained with no subluxation or encroachment on the neural foramina. The dorsal spine showed slight irregularity of the endplates on the inferior margin at T5 and superior margin of T9, which was probably related to old Scheurrman's disease with associated degenerative changes. Slight disc narrowing was seen at T7-8, described as mild degenerative changes at the mid-dorsal spine. The lumbar spine showed vertebral body heights and disc spaces normally maintained with no evidence of fracture or subluxation. Appellant continued at work under restrictions as recommended by Dr. LeRoy.

By decision dated May 18, 1989, OWCP found that appellant's earnings in private employment represented her wage-earning capacity and reduced her monetary compensation.

In August 1999, Dr. Uday S. Uthaman, Board-certified in family medicine, began pain management. He submitted monthly treatment reports addressing findings on physical examination describing appellant's medication regimen and diagnostic testing.[2] The record reflects that appellant began work part time as an office nurse for about 20 hours a week through June 9, 2001. From September 2001 until February 2007, she worked part time as a school nurse.

On December 17, 2007 appellant, through her representative, requested compensation for total disability. She submitted a May 9, 2007 report from Dr. LeRoy, who advised that she had been under his care since March 31, 1980. Dr. LeRoy diagnosed cervicodorsal myositis (mild bilateral ligamentous strain) with sensory radiculopathy; post-traumatic occipital cervicogenic headaches; thoracic outlet syndrome, hyperabduction type; lumbosacral strain with bilateral

[2] Additional diagnostic testing on September 21, 1990 revealed a small disc herniation at L4-5 not definitely compressing the neural canal and disc bulging at L5-S1 with degenerative changes. A February 7, 1991 cervical magnetic resonance imaging (MRI) scan showed a small central disc herniation at C5-6 with no evidence of spinal cord compression. A March 23, 2001 cervical spine MRI scan showed all vertebral bodies to be well maintained with mild degenerative disease at C4-5 and C5-6 and no herniated disc, spinal stenosis or narrowing of the neuroforamina. A June 21, 2001 electromyogram of the right upper extremity and neck was reported as normal. On October 10, 2001 a lumbar MRI scan was obtained that showed no vertebral compression fracture or spondylolisthesis. There was mild narrowing at L4-5 and L5-S1 with a small disc herniation by no cord compression.

sciatica; peptic ulcer by history; and post-traumatic stress/anxiety/depression. He addressed appellant's conservative management, which included activity restrictions, medications, physical therapy and serial nerve blocks; but she had not reached maximum medical improvement and progressively worsened.

Monthly treatment records for 2007 and 2008 from Dr. Uthaman were also submitted to the record. He noted appellant's complaint of pain in the back and treatment with medication. Dr. Uthaman did not address whether she was disabled from continuing employment as a nurse due to residuals of her accepted condition. On December 27, 2007 he provided a work restriction evaluation advising that appellant was capable of sedentary duty, four hours a day within prescribed limitation. In a March 30, 2009 work restriction evaluation, however, Dr. Uthaman reported her as totally disabled due to chronic pain syndrome, cervical/dorsal multiple disc lesions and myositis. Subsequent work evaluation reports dated in 2009 and 2010 from him reiterated his opinion that appellant was totally disabled or could do zero hours of work.

In a January 10, 2011 report, Dr. LeRoy noted that he had not seen appellant since December 13, 2009 and that her condition had progressed since that time. He diagnosed occipitofrontal headaches secondary to muscle strain; spinal spondylosis at multiple levels by x-ray; lumbosacral strain and sprain with radiculopathy, right greater than left; reflex sympathetic dystrophy or complex regional pain syndrome, clinical, suspected; and noted her sensitivity to succinylcholine. Dr. LeRoy advised that appellant's physical activity was limited and that she was not able to work.

In reports dated March 14, 2011, Dr. Uthaman noted appellant's complaint of back, leg, arm, neck and head pain. He diagnosed chronic pain syndrome; cervical and dorsal myositis; lumbar and thoracic spondylosis; degenerative arthritis of multiple discs in the neck and back; and stable depression with anxiety and headache. Dr. Uthaman described appellant's pain management regimen and advised that she could not work. He submitted additional monthly treatment records reiterating his opinion that she was totally disabled.

On December 7, 2011 OWCP referred appellant to Dr. Robert Franklin Draper, Jr., Board-certified in orthopedic surgery, for a second-opinion evaluation. In a January 9, 2012 report, Dr. Draper reviewed the history of injury, accepted conditions and medical treatment. He reviewed appellant's treatment by Dr. LeRoy and Dr. Uthaman for pain primarily in her neck and back. Dr. Draper provided findings on range of motion examination of her neck and motor function in the upper extremities. He noted that appellant had a give-away weakness in a global fashion that was nonanatomic. Straight leg raising tests were negative at 90 degrees bilaterally in the sitting position. Dr. Draper diagnosed lumbosacral strain, lumbar spondylosis and degenerative arthritis of the lumbar spine; thoracic strain with thoracic spondylosis; cervical strain and rule-out cervical spondylosis and degenerative cervical disc disease. He advised that there was no evidence for reflex sympathetic dystrophy as mentioned by Dr. LeRoy or evidence of thoracic outlet syndrome.

Dr. Draper stated that appellant sustained soft tissue injuries in 1980 to her cervical, thoracic and lumbar spine with musculature strains. His examination did not document any specific neurological deficits or problems and he advised that her pain in the neck and back was

related to her underlying degenerative conditions. Dr. Draper noted that arthritis in the lumbar spine contributed to appellant's low back discomfort. He advised that she did not have any residuals from her work injury in 1980, noting that the accepted soft-tissue strains had resolved within four weeks. Dr. Draper found appellant at maximum medical improvement and advised that her ongoing cervical and back problems were not employment related due to the degenerative disease in the lumbar and thoracic spine. He found that she was capable of light-duty work in a job that did not require lifting more than 20 pounds occasionally or 10 pounds frequently. Dr. Draper advised that appellant could work full time with these limitations and he found no indication for surgical intervention. In an attached work capacity evaluation he listed that she could work eight hours daily with permanent restrictions of sitting six hours, walking and standing two hours and a 10-pound weight restriction. Dr. Draper advised that the restrictions were not due to the accepted conditions.

OWCP found a conflict in medical opinions arose between Dr. Draper and Dr. LeRoy on whether appellant had residuals of her accepted conditions and her capacity for work. It referred her to Dr. Karl Rosenfeld, a Board-certified orthopedic surgeon, for an impartial examination.[3]

In a March 7, 2012 report, Dr. Rosenfeld reviewed the history of injury and medical treatment. He addressed the reports of diagnostic studies and office records of the various examining physicians. Appellant complained primarily of back and bilateral leg pain involving her entire legs to the feet. On examination, straight leg maneuvers on the left side reproduced back pain with no response on the right. In the prone position, appellant cried out. She had no muscle spasm but was subjectively tender wherever touched, including her entire lumbar spine, buttocks and sacroiliac joints. Dr. Rosenfeld stated that, by objective measures, it was a normal examination with significant subjective findings. He provided an extensive review of the diagnostic studies, physical therapy records and office records of Dr. LeRoy and Dr. Uthaman and the report of Dr. Draper.

Dr. Rosenfeld stated that he did not read Dr. Draper's report until after his examination but came to a similar conclusion. He noted from the history that appellant sustained soft tissue injuries in 1980 but went on to develop a significant debilitating state. Dr. Rosenfeld stated that her diagnostic studies revealed progressive changes that were degenerative and not due to her work injury. Rather, he described the degenerative changes as part of the aging process. Dr. Rosenfeld agreed with Dr. Draper that appellant's degenerative state was responsible for her significant symptoms and disability. He determined that her ongoing condition was degenerative in nature and not related to the trauma sustained in 1980. Dr. Rosenfeld advised that appellant's ongoing restrictions were due to her degenerative disease and that she could work full time in a light-duty capacity with a 10-pound lifting restriction.

On April 11, 2012 OWCP proposed to terminate appellant's compensation benefits, based on the referee opinion of Dr. Rosenfeld.

Appellant disagreed with the proposed termination. She submitted an April 17, 2012 report from Dr. LeRoy, who opined that her medical condition had materially changed. Dr. LeRoy reiterated the prior diagnoses and advised that appellant had developed symptoms of

[3] On February 27, 2012 Dr. LeRoy stated his disagreement with the findings by Dr. Draper.

bladder dysfunction, bowel incontinence and saddle anesthesia, which were consistent with a diagnosis of cauda equina syndrome plus an additional diagnosis of spinal arachnoiditis. He stated his disagreement with Dr. Rosenfeld's medical opinion and recommended that she have consultations with a neurologist, urologist and proctologist to address the cauda equina syndrome. In a May 7, 2012 report, Dr. Uthaman reiterated his prior findings and conclusions.

In a supplemental report dated May 21, 2012, Dr. Rosenfeld reviewed Dr. LeRoy's April 17, 2012 report. He disagreed with the diagnosis of cauda equina syndrome, stating that such diagnosis was made in less than one percent of herniated discs. Dr. Rosenfeld stated that diagnostic testing revealed a lack of significant disc herniation and reiterated that his physical examination demonstrated no objective findings of a neurological deficit. He noted that, on examination, appellant was highly functional with no evidence to support that her current symptoms were caused by the 1980 employment injury.

In a June 14, 2012 decision, OWCP terminated appellant's compensation benefits effective July 1, 2012. It found that the weight of medical opinion was represented by the impartial report of Dr. Rosenfeld.

On July 16, 2012 appellant requested a review of the written record. In reports dated June 28 and August 23, 2012, Dr. Uthaman reiterated his findings and conclusions.

In an October 17, 2012 decision, an OWCP hearing representative found that the weight of the medical evidence rested with Dr. Rosenfeld and affirmed the June 14, 2012 decision.

LEGAL PRECEDENT -- ISSUE 1

A wage-earning capacity decision is a determination that a specific amount of earnings, either actual earnings or earnings from a selected position, represents a claimant's ability to earn wages. Compensation payments are based on the wage-earning capacity determination and it remains undisturbed until properly modified.[4] OWCP's procedures manual provides that, "[i]f a formal loss of wage-earning capacity decision has been issued, the rating should be left in place unless the claimant requests resumption of compensation for total wage loss. In this instance the [claims examiner] will need to evaluate the request according to the customary criteria for modifying a formal loss of wage-earning capacity."[5] Once the wage-earning capacity of an injured employee is determined, a modification of such determination is not warranted unless there is a material change in the nature and extent of the injury-related condition, the employee has been retrained or otherwise vocationally rehabilitated or the original determination was, in fact, erroneous.[6] The burden of proof is on the party attempting to show a modification of the wage-earning capacity determination.[7]

[4] *Katherine T. Kreger*, 55 ECAB 633 (2004).

[5] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Reemployment: Determining Wage-Earning Capacity*, Chapter 2.814.9(a) (October 2009).

[6] *Stanley B. Plotkin*, 51 ECAB 700 (2000).

[7] *Id.*

Chapter 2.814.11 of OWCP's Procedure Manual provides that a formal loss of wage-earning capacity will be modified when: (1) the original rating was in error; (2) the claimant's medical condition has changed; or (3) the claimant has been vocationally rehabilitated. The party seeking modification of a formal loss of wage-earning capacity decision has the burden to prove that one of these criteria has been met.[8]

ANALYSIS -- ISSUE 1

Appellant's claim was accepted for sprains of the cervical, thoracic and lumbar spine and for lumbago sustained on January 31, 1980. She received compensation for intermittent disability for work before going to work in the private sector as a nurse. In 1989, OWCP found that her actual earnings as a nurse in private employment represented her wage-earning capacity. In 2001, appellant began part-time employment and worked until February 2007 when she stopped and claimed total disability. The Board finds that the medical evidence of record does not establish that there was a material change in her accepted conditions such that she became totally disabled due to residuals of her accepted conditions.

Dr. Uthaman provided pain management beginning in 1999 and he provided monthly treatment records. The reports contemporaneous to appellant's claim of total disability in 2007, noted treatment of back pain that was maintained with medication. Dr. Uthaman did not address her capacity for work or whether residuals of her accepted conditions prevented her from continuing in employment as a nurse. On December 27, 2007 he provided a work restriction evaluation, noting that appellant was capable of work for four hours a day, with lifting limited to 10-pound sedentary duty. In a March 30, 2009 work restriction form, Dr. Uthaman listed that she was totally disabled for work. The Board notes that he did not provide a narrative opinion adequately addressing how residuals of appellant's accepted back conditions caused disability for continuing in her work as a nurse. The medical records from Dr. Uthaman dated in 2007 appear to support her capacity for part-time employment subject to physical restrictions through December 27, 2007. To be probative on the issue of disability, a physician's opinion should be based on a full and accurate factual and medical background of the claimant, must be one of reasonable medical certainty and be supported by rationale explaining how the disability is due to the conditions accepted in the claim.[9]

While he advised that appellant could not work beginning in March 2009, Dr. Uthaman diagnosed multiple conditions that were not accepted by OWCP as employment related, including chronic pain syndrome, cervical and dorsal myositis, lumbar and thoracic spondylosis, degenerative arthritis of multiple discs in the neck and back, stable depression and anxiety and headache. He did not sufficiently explain how her disability related to her February 28, 1980 employment injury or how the residuals due to her accepted injury had materially changed so as to cause her inability to continue to work as a nurse under sedentary restrictions.

Dr. LeRoy began treating appellant in March 1980. He stated in a May 9, 2007 report that her condition had progressively worsened. Dr. LeRoy diagnosed multiple conditions that

[8] *See supra* note 5 at Chapter 2.814.11 (October 2009).

[9] *See J.M.*, 58 ECAB 303 (2007).

have not been accepted as employment related: cervicodorsal myositis (mild ligamentous strain bilateral) with sensory radiculopathy; post-traumatic occipital cervicogenic headaches; thoracic outlet syndrome, hyperabduction type; lumbosacral strain with sciatica, bilaterally; peptic ulcer by history; post-traumatic stress/anxiety/depression; occipitofrontal headaches secondary to muscle strain; spinal spondylosis at multiple levels by x-ray; lumbosacral strain and sprain with radiculopathy, right greater than left; reflex sympathetic dystrophy or complex regional pain syndrome, clinical, suspected; sensitivity to succinylcholine; cauda equina syndrome with bladder and bowel incontinence; and spinal arachnoiditis. He stated that appellant's condition had worsened over the years with increasing symptoms, but he did not sufficiently address how residuals of the accepted back conditions had materially changed to cause total disability for work. The Board finds that Dr. LeRoy did not provide a reasoned explanation as to how her employment-related conditions had materially worsened such that she was no longer able to continue in a sedentary work capacity.

The Board notes that subsequently acquired conditions are not considered in determining wage-earning capacity.[10] Neither Dr. LeRoy nor Dr. Uthaman adequately addressed appellant's disability for work commencing in 2007 as claimed, nor did they provide sufficient medical rationale explaining how the additional diagnosed conditions were caused or contributed to by her injury in 1980.[11] Both Dr. Draper, who provided a second-opinion evaluation for OWCP and Dr. Rosenfeld, the referee physician, indicated that appellant's accepted employment injuries had resolved. The Board concludes that the opinions of Dr. Uthaman and Dr. LeRoy are insufficient to establish that her accepted conditions materially changed such that the wage-earning capacity determination should be modified.

The medical evidence submitted by appellant does not establish a material worsening of her injury-related conditions and is insufficient to establish total disability commencing in 2007 due to her accepted conditions.[12]

LEGAL PRECEDENT -- ISSUE 2

Once OWCP accepts a claim and pays compensation, it has the burden of justifying modification or termination of an employee's benefits. It may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.[13] 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.[14] The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability. To terminate authorization for medical treatment, OWCP must

[10] *See John D. Jackson*, 55 ECAB 465 (2004).

[11] *See A.P.*, Docket No. 08-1822 (issued August 5, 2009).

[12] *P.C.*, 58 ECAB 504 (2007).

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

[14] *Id.*

establish that appellant no longer has residuals of an employment-related condition, which require further medical treatment.[15]

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.[16] When the case is referred to an 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.[17]

ANALYSIS -- ISSUE 2

OWCP determined that a conflict in medical opinion arose between Dr. LeRoy, for appellant and Dr. Draper, the second opinion examiner, as to whether appellant had residuals of her accepted back conditions and was totally disabled. It referred her to Dr. Rosenfeld for an impartial evaluation.

In reports dated March 7 and May 21, 2012, Dr. Rosenfeld reviewed the medical evidence of record, including diagnostic studies. He advised that, by objective measures, his examination was normal, indicating that significant subjective findings included restricted range of motion of the back, apparent difficulty in moving about and appellant's response to probing of the back. Dr. Rosenfeld indicated that, in 1980, she sustained only a soft tissue injury and that the progressive changes seen in diagnostic studies were of a degenerative nature and were the cause of her current condition. He advised that appellant's current symptoms were not caused by the 1980 employment injury and found that she could work eight hours a day. Dr. Rosenfeld's recommended physical restrictions were not work related but due to the degenerative disease and changes that the physician stated were part of the aging process.

The Board finds that, as Dr. Rosenfeld provided a comprehensive, well-rationalized opinion in which he clearly advised that any residuals of appellant's accepted conditions had resolved, his opinion is entitled to the special weight accorded an impartial examiner and constitutes the weight of the medical evidence.[18]

The medical evidence appellant subsequently submitted is insufficient to overcome the weight accorded Dr. Rosenfeld as an impartial medical specialist. Both Dr. LeRoy and Dr. Uthaman submitted additional reports. Dr. Uthaman essentially reiterated his findings and conclusions but did not explain how appellant's current back condition or disability related to the 1980 employment injury. While Dr. LeRoy stated his disagreement with Dr. Rosenfeld's opinion; he was on one side of the conflict in medical evidence. The Board has held that reports from a physician who was on one side of a medical conflict that an impartial specialist resolved,

[15] *Fred Simpson*, 53 ECAB 768 (2002).

[16] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

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

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

are generally insufficient to overcome the weight accorded to the report of the impartial medical examiner or to create a new conflict.[19] In this regard, Dr. LeRoy did not further address how appellant's back condition for which he found disability was caused or contributed to by the 1980 injury.

Dr. Rosenfeld found that the residuals of appellant's accepted conditions had ceased and that she was presently disabled due to degenerative disease arising as part of the aging process. He advised that she could return to work with physical restrictions unrelated to her 1980 injury. The Board notes that Dr. Rosenfeld's opinion is entitled to the special weight accorded an impartial medical examiner.[20] The additional reports from Drs. Uthaman and LeRoy are insufficient to overcome the weight accorded Dr. Rosenfeld as the impartial medical specialist. The Board finds that the weight of medical opinion supports that appellant's injury-related conditions resolved. OWCP met its burden of proof to terminate her compensation benefits.

Appellant may submit new evidence or argument regarding this issue, with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a).

CONCLUSION

The Board finds that appellant did not meet her burden of proof to modify the May 18, 1989 wage-earning capacity determination. OWCP met its burden of proof to terminate her compensation benefits as of July 1, 2012.

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

[20] *See Sharyn D. Bannick*, *supra* note 18.

ORDER

IT IS HEREBY ORDERED THAT the October 17, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 10, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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