U.S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of MICHAEL A. WEICHMANN and DEPARTMENT OF LABOR, WAGE & HOUR DIVISION, Roswell, N.M.

Docket No. 96-1672; Submitted on the Record;
Issued May 14, 1998

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON, WILLIE T.C. THOMAS

The issue is whether the Office of Workers' Compensation Programs properly terminated compensation benefits after May 1, 1994 for the accepted aggravation of appellant's preexisting emotional condition.

On September 4, 1992 appellant, then a 43-year-old wage and hour investigator, sustained an injury in the performance of duty while replacing a spare tire. The Office accepted his claim for lumbar muscle spasm and central subligamentous disc herniation at L5-S1. Appellant expanded his claim to include an emotional condition.

In a report dated December 16, 1992, Dr. Steven Michael Cobb, a clinical psychologist who saw appellant as a referral from a consulting neurosurgeon, related his psychological evaluation of appellant on December 7 and 8, 1992, which included a one-hour interview and six hours of testing. He noted that appellant was relating his current symptoms to the accident that occurred on September 4, 1992, which he described. Dr. Cobb related appellant's symptoms, relevant history, psychosocial history, substance abuse history, and findings from mental status examination and psychological testing. He gave a principal diagnosis of major depression, recurrent, moderate to severe, secondary to acute pain condition. Dr. Cobb also diagnosed anxiety disorder, not otherwise specified (NOS), mixed for multiple types with obsessive compulsive, panic, generalized and phobic prominent, rule out sleep panic disorder. He diagnosed physical disorders or conditions as acute low back condition, right leg pain, neck pain, head pain, muscle tension and sleep disturbance. He rated the severity of psychosocial stressors as moderate to severe and cumulative for occupational, familial and physical condition. Dr. Cobb reported that appellant was suffering with a depressive disorder that was recurrent and associated with reactions of emotional loss to psychosocial stressors. At present, he stated, the

primary stressor appeared to be an acute low back pain condition that was job related in origin. Dr. Cobb explained:

> "This is particularly difficult for [appellant] who also indicates an anxiety disorder of mixed type with neurotic tendencies, along with work-related career concerns. Furthermore, the depressive condition is further complicated by [his] apparent inability to manage his anxiety, with low self-esteem. Sleep deprivation is not helpful and contributes to depression and anxiety symptoms. The potential for sleep panic disorder developing is also a concern. Long-term prognosis with psycho therapy, as well as prescribed medical treatments, is currently estimated to be guarded to fair."

In a report dated January 13, 1993, Dr. Paul T. Turner, appellant's attending neurosurgeon, stated that appellant's low back pain was improved some and his level of symptoms decreased since December 2, 1992. Appellant's posterior cervical/thoracic secondary muscle spasm had resolved for the most part, he stated, but there was still some abnormal muscle dysfunction in the left lumbar region and then very low in his back. Dr. Turner stated:

> "My impression continues the same -- that is, L5-S1 disc disease with an annular tear and disc bulge but without any disc herniation requiring consideration of surgical treatment. The musculoskeletal pain that bothers him intermittently is secondary to this basic underlying spine problem, in my view, and I do expect him to have some modest level of symptoms, depending on his activities in the future. However, I think he is at a point where the natural history would be to gradually resolve these symptoms spontaneously. He has been appropriately instructed in exercises and indeed has been very faithful in doing those. I don't think regular follow-up is necessary neurosurgically. I have made an appointment for him in two and one-half months when, if appropriate, I think we could offer an opinion regarding maximum medical improvement following this single level disc injury and what permanent impairment may be appropriate to assign to it."

In a report dated June 29, 1993, Dr. Turner advised the Office that the central subligamentous disc herniation at the L5-S1 level was connected to the work injury of September 4, 1992. He stated:

> "[Appellant] does continue to have a back condition, *i.e.*, an injured L5-S1 disc connected to the work incident of September 4, 1992. That condition has resolved, but with some modest persistent symptoms of ache and some decreased ability to accept manual loading of that disc with experiencing some ache. I think the condition is resolved as much as it will. I believe [appellant] to be completely functional in his usual activities as he describes them to me and is not in need of other neurosurgical treatment. This condition in my view cannot resolve completely or go back to a normal baseline, however, it can resolve, as his has, to the point that he is able to do ordinary activities and practically he is not disabled from this disc problem."

The Office referred appellant to Dr. Lester M. Libo, a clinical psychologist specializing in chronic pain management, for psychological testing.

In a report dated July 20, 1993, Dr. Libo stated that he had seen many patients with emotional problems stemming from their physical injuries and resultant vocational, avocational and social problems. Appellant, he stated, having the additional predisposing characteristic of a depressed and chronically anxious, rigid, obsessive-compulsive personality, would be especially vulnerable to experience the problems of a typical chronic pain patient: depression, marital problems, sleep problems, frustrations and worries about not being fully functional, social withdrawal, and inability to work. Dr. Libo concluded as follows:

> "In conclusion, regarding the initial question of the role of the September 1992 injury, it would seem that, for this rather emotionally fragile individual, any stressful event that threatens his need for order and control and makes him prone to failure could serve as the precipitating factor in debilitating depression and/or anxiety. His current behavior might also be understood as an extreme expression (because of his predisposing personality problems) of a commonly-seen pattern of emotional and behavioral consequences of chronic pain."

The Office referred appellant, together with Dr. Libo's report, copies of medical reports and a statement of accepted facts, to Dr. Juan M. Hernández, a psychiatrist, for a second opinion on whether appellant had an emotional condition causally related to the incident of September 4, 1992.

In a report dated October 8, 1993, Dr. Hernández related appellant's history of injury, complaints, symptoms, past and family psychiatric history, and findings on mental status examination. He provided principal diagnoses of obsessive-compulsive disorder, moderate to severe major depression, and generalized anxiety disorder. He diagnosed no personality disorder. Dr. Hernández commented as follows:

> "It would appear that the incident of September 4, 1992 clearly precipitated a worsening of [appellant's] obsessive ruminations about his health, specifically his low back syndrome. In my opinion, the patient's depression is probably very closely related to his diagnosis of [o]bsessive [c]ompulsive [d]isorder which is a preexisting emotional condition. The injury has caused [appellant's] thoughts to become focused in an obsessive manner on his low back pain, health concerns and other insecurities thereby causing depression. In terms of treatment, I recommend treatment of both obsessions and depression with a [s]elective [s]eratonin [r]euptake [i]nhibitor (SSRI) drug, such as [s]ertraline or [f]luoxetine and treating the patient's anxiety with a benzodiazepine, such as [c]lonazepam. I also recommend behaviorally-oriented psychotherapy focused on the patient's obsessive thinking. Twenty behaviorally-oriented psychotherapy sessions should be adequate for the treatment of this acute episode. Treatment with medications could be indefinite, since [o]bsessive [c]ompulsive [d]isorder is a chronic condition with periodic exacerbations."

On October 19, 1993 the Office notified appellant that it had received and reviewed the second-opinion report of Dr. Hernández and was accepting his claim for the additional condition of "temporary aggravation of preexisting anxiety disorder not to exceed May 1, 1994." The Office authorized appellant to obtain care from Dr. Cheryl A. Hollingsworth, a clinical psychologist, not to exceed May 1, 1994.

In an April 14, 1994 report to the Office, Dr. Hollingsworth stated that she had been treating appellant since November 15, 1993 for anxiety disorder NOS and dysthymia. She stated that appellant's primary problem was anxiety leading to depression. Dr. Hollingsworth advised as follows: "[Appellant] has made improvement with therapy, however, I am requesting more sessions to continue treatment for his periods of regression, anxiety and depression."

On April 28, 1994 the Office requested more information from Dr. Hollingsworth, including clinical records and an opinion on the continuing relationship between the specific work incident of September 4, 1992 and the accepted condition. "In other words," the Office stated, "please provide an explanation of how and in what manner his current emotional condition and seeming difficulty in dealing with life stressors continues to relate to a work injury which occurred approximately 18 months ago, particularly in light of his recovery from the back condition which resulted from the work incident."

Having received no response from Dr. Hollingsworth, the Office issued a decision on January 10, 1995 finding that the evidence of file failed to demonstrate a causal relationship between the injury and the need for the claimed treatment. In the attached memorandum, the Office noted that it was previously determined that the preexisting emotional condition was only temporarily aggravated and resolved by May 1, 1994. The Office found that appellant "has not submitted medical evidence to support that psychiatric medical care after May 1, 1994 was the result of residuals of the job injury."

The Office received a May 23, 1994 report from Dr. Hollingsworth, which was date stamped as received on January 25, 1995. In this report, Dr. Hollingsworth stated that it was her main concern that additional treatment be approved as quickly and efficiently as possible because it was her profession opinion that appellant needed continuing therapy "NOW" and that his panic attacks, his sleep patterns, and his depression worsened the longer the hope of treatment was delayed. Responding to the Office's April 28, 1994 request for additional information, Dr. Hollingsworth advised that she was attaching an initial evaluation dated November 15, 1993 and office progress notes from November 18, 1993 through April 28, 1994. She also reported as follows:

> "Regarding the question of the continuing relationship between the September 4, 1992 injury and how his current emotional condition and difficulty dealing with life stressors -- [appellant's] emotional detachment appears to be of long duration and although progress has been made, at this time his diagnosis resulting from his injury is likely to be fixed. He is an emotionally fragile individual and any stressful events are met with extreme anxiety and panic.
>
> "It is my opinion that [appellant's] continued need for psychotherapy treatment results from [his day-to-day work activities as described in his position

description, from the September 4, 1992 work injury, and from his prior emotional condition]. It was noted that [appellant] had past medical history of major depression and obsessive compulsive disorder. On many occasions in therapy sessions [appellant] has noted anxiety over his current day-to-day work activities. It was noted that before his September 4, 1992 injury he was not experiencing these difficulties and that panic attacks, anxiety, and depression worsened as he worried about unknown consequences (job related *i.e.*, possible threat to his job; panic and obsessions at work). [Appellant] requires continued therapy in order to function at this point.

"[Appellant's] preexisting obsessive compulsive disorder, anxiety disorder and prior history of major depression, with a family history of manic depression should not have a lot of bearing on this case, as [appellant] was not in treatment just prior to his injury. After his injury his thoughts were focused in an obsessive manner which is characteristic of one with this preexisting emotional condition. The panic attacks, 'terror,' and hopelessness are symptoms developed after the injury and are ongoing."

* * *

"I recommend that [appellant] return to this clinic as soon as possible for continued psychotherapy. One to two times per week, until the level of confidence has been reached that we had obtained up until the last few sessions in April. Then once a week 45 minute psychotherapy and medication management. I do not feel confident in stating an exact number of therapy session[s] that would be adequate for treatment of this acute condition because treatment/medications may be indefinite since this is a chronic condition with periodic exacerbations."

Appellant requested a review of the written record.

In a decision dated January 31, 1996, the Office affirmed its January 10, 1995 decision denying continuing psychotherapy after May 1, 1995. The Office found that there was no rationalized medical evidence to support appellant's contention that his need for additional psychotherapy was causally related to the September 4, 1992 work injury. The Office found that Dr. Hollingsworth did not cite particular employment factors as a cause or aggravating factor and that she offered no explanation of how these factors might affect a preexisting condition. Dr. Hernández had indicated that 20 behaviorally oriented psychotherapy sessions was adequate for the treatment of the aggravation of appellant's obsessive compulsive disorder, the Office noted, and he provided medical rationale to support his opinion. The Office found that his opinions therefore constituted the weight of the medical evidence and established that the need for continuing psychiatric medical care was not due to the September 4, 1992 work injury.

The Board finds that the Office has not met its burden of proof to justify terminating appellant's compensation benefits after May 1, 1995.

Once the Office accepts a claim, it has the burden of proof to justify termination or modification of compensation benefits.[1] 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.[2] Furthermore, the right to medical benefits for an accepted condition is not limited to the period of entitlement for disability. To terminate authorization or medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition that require further medical treatment.[3]

When the Office notified appellant on October 19, 1993 that it had received and reviewed the second-opinion report of Dr. Hernández, it made two important decisions in his case: First, it accepted his claim for the additional condition of temporary aggravation of preexisting anxiety disorder and authorized treatment from Dr. Hollingsworth. Second, it found that this temporary aggravation would cease no later than May 1, 1994 and was therefore denying treatment after that date. The Board has held that the fact that the Office accepts an employee's claim for a specified period of disability does not shift the burden of proof to the employee: The burden is on the Office with respect to the period subsequent to the date of termination or modification.[4] Accordingly, before there is any discussion of whether appellant has submitted sufficient medical opinion evidence to establish a causal relationship between his accepted employment injury and the need for psychotherapy after May 1, 1994, the Board must review the medical opinion evidence to determine whether it justified the Office's prospective termination of compensation benefits after May 1, 1994.

The Office based its acceptance of a temporary aggravation primarily on the October 8, 1993 report of Dr. Hernández, the second-opinion psychiatrist who diagnosed obsessive-compulsive disorder, moderate to severe major depression, and generalized anxiety disorder. Dr. Hernández supported that the incident of September 4, 1992 clearly precipitated a worsening of appellant's preexisting obsessive compulsive disorder by causing his thoughts to become focused in an obsessive manner on his low back pain. He also supported that appellant's depression was probably very closely related to the diagnosis of obsessive compulsive disorder.

On the issue of the duration of the worsening, however, Dr. Hernández stated only that 20 behaviorally oriented psychotherapy sessions "should be adequate" for the treatment of this acute episode. He did not elaborate. The Board cannot discern a rational basis for this opinion, nor can it determine whether the number of sessions reported constitutes anything more than mere guesswork on the part of the psychiatrist. Rationale is necessary to demonstrate that a physician's opinion is sound and logical, and it is particularly important in this case, where the physician is looking forward and predicting that a specific number of treatment sessions should

[1] *Harold S. McGough*, 36 ECAB 332 (1984).

[2] *Vivien L. Minor*, 37 ECAB 541 (1986); *David Lee Dawley*, 30 ECAB 530 (1979); *Anna M. Blaine*, 26 ECAB 351 (1975).

[3] *Furman G. Peake*, 41 ECAB 361, 364 (1990).

[4] *See Raymond M. Shulden*, 31 ECAB 297 (1979); *Anna M. Blaine (Gilbert H. Blaine)*, 26 ECAB 351 (1975).

resolve the work-related worsening of a preexisting emotional condition. Contrary to the Office's finding on January 31, 1996, the Board finds that the opinion of Dr. Hernández on the issue of the duration of the work-related worsening is unsupported by any rationale.[5] For this reason, the Board finds that the October 8, 1993 report of Dr. Hernández is insufficient to justify the Office's prospective termination of benefits after May 1, 1994.

Further, the April 14 and May 23, 1994 reports of Dr. Hollingsworth serve only to undermine the opinion of Dr. Hernández on the duration of the work-related worsening of appellant's obsessive compulsive disorder. Dr. Hernández saw appellant on one occasion in June 1993. Dr. Hollingsworth began periodic psychotherapy sessions with appellant in November 1993, and she was currently treating appellant when she reported on April 14, 1994 that more sessions were necessary. On May 23, 1994 she explained that the diagnosis resulting from appellant's employment injury was likely to be fixed and that his continued need for psychotherapy treatment resulted from, among other factors, the September 4, 1992 work injury. Unlike Dr. Hernández, she did not feel confident in stating an exact number of therapy sessions that would be adequate for treatment of appellant's acute condition. Because Dr. Hollingsworth was currently treating appellant and observing his progress through April 1994, she was in a better position to determine whether the work-related worsening reported by Dr. Hernández had in fact ceased by May 1, 1994. In addition, the Board notes that the opinion of Dr. Hollingsworth on the issue of continuing residuals is no less reasoned than the opinion of Dr. Hernández on the expected duration of the work-related worsening. The Office discounted Dr. Hollingsworth's opinion, however, by misplacing the burden of proof on appellant and finding that her reports offered no explanation to establish the element of causal relationship.

Finally, the Office based its prospective termination of benefits in part on a misreading of Dr. Turner's June 29, 1993 report. In that report, Dr. Turner, appellant's neurosurgeon, stated that appellant does continue to have an injured L5-S1 disc connected to the work incident of September 4, 1992. Although he stated that the condition was resolved as much as it would, and that it had resolved to the point that appellant was able to do ordinary activities, Dr. Turner made clear that the condition could not resolve completely or go back to a normal baseline. "And that condition has resolved," he stated, "but with some modest persistent symptoms of ache and some decreased ability to accept manual loading of that disc without experiencing some ache."

The Office misread Dr. Turner's statements as supporting a resolution of the accepted central subligamentous disc herniation at the L5-S1 level. On its Form CA-800, FECA Nonfatal Summary, the Office described the accepted herniation as "resolved." When it requested additional information from Dr. Hollingsworth on April 28, 1994, the Office asked her to explain how appellant's current emotional condition and seeming difficulty in dealing with life stressors continued to relate to a work injury that occurred approximately 18 months earlier, "particularly in light of his recovery from the back condition which resulted from the work incident." Further, in the memorandum supporting its January 10, 1995 decision, the Office found that the evidence established that appellant sustained an injury resulting in lumbar muscle spasm, central subligamentous disc herniation "which has subsequently resolved," and temporary aggravation

[5] Dr. Hernández did not report that the work-related worsening would resolve by May 1, 1994. The Office selected that date on grounds that are not apparent from the record.

of preexisting anxiety. In point of fact, Dr. Turner's report supported only a maximum medical improvement with continuing symptoms and decreased ability. It did not establish a resolution of the work-related back condition that precipitated a worsening of appellant's preexisting obsessive compulsive disorder.

As the evidence in this case fails to justify the prospective termination of compensation benefits after May 1, 1994, the Board finds that the Office has not discharged its burden of proof.

The January 31, 1995 decision of the Office of Workers' Compensation Programs is reversed.

Dated, Washington, D.C.
May 14, 1998

Michael J. Walsh
Chairman

David S. Gerson
Member

Willie T.C. Thomas
Alternate Member