U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of BARBARA EICHLER and FEDERAL EMERGENCY MANAGEMENT AGENCY, REGION VI FEDERAL REGIONAL CENTER, Denton, Tex.

Docket No. 96-1151; Submitted on the Record;
Issued October 6, 1998

DECISION and ORDER

Before DAVID S. GERSON, BRADLEY T. KNOTT,
A. PETER KANJORSKI

The issue is whether the Office of Workers' Compensation Programs properly terminated appellant's compensation effective December 9, 1995 on the grounds that appellant had no work-related disability or condition after that date causally related to accepted cervical, lumbar, thoracic, wrist and right shoulder strains, and bilateral knee contusions sustained in the performance of duty on January 23, 1994.

The Office accepted that appellant, then a 53-year-old telephone service representative, sustained cervical and lumbar strains, bilateral wrist, right shoulder and thoracic strains and bilateral knee contusions in a January 23, 1994 fall on gravel, in which she landed on both hands and her right side. Appellant stopped work on January 24, 1994 and did not return.[1] She received continuation of pay, compensation on the daily rolls, then the periodic rolls beginning June 11, 1994.

In a February 1, 1994 report, Dr. Tero Walker, an attending Board-certified orthopedist, provided a history of injury, related appellant's left arm, neck and low back complaints, and held her off work pending diagnostic studies.[2] On April 20, 1994 he diagnosed myalgia and osteoarthritis and held appellant off work until May 24, 1994.

In a June 14, 1994 report, Dr. John D. Halcomb, an attending orthopedic surgeon, provided a history of injury, noted her complaints of neck and low back pain, headaches, and "limited use of the left arm and an area of ache and pain in … the deltoid patch, left greater than right." On examination, Dr. Halcomb found full range of neck motion, normal muscle strength

[1] Appellant's case was referred to a rehabilitation nurse consultant, who provided services from February to December 1995.

[2] February 1, 1994 electromyogram (EMG) and nerve conduction velocity studies of the left upper extremity were indicative of carpal tunnel syndrome. April 19, 1994 EMG and nerve conduction velocity studies of the left upper extremity were within normal limits.

of the upper and lower extremities, mild tenderness in the right paracervical and trapezius muscles, and a tender right sacroiliac joint with positive FABER test. Cervical and lumbar x-rays showed "no significant abnormalities." Dr. Halcomb diagnosed "[p]ossible nerve root encroachment cervical spine," and "[p]robable right sacroiliac joint discomfort." He submitted periodic reports.[3]

In an October 4, 1994 report, Dr. Halcomb noted that lumbar myelography and computerized tomography (CT) scans showed spinal stenosis at L4-5 "due to bulging disc, ligamentum flavum hypertrophy and osteophyte formation," with mild disc bulging at L5-S1. He recommended surgical decompression and anterior cervical fusion at C4-6.

In December 23, 1994 reports, Dr. Halcomb noted "right posterior lateral thigh and calf pain" increased by activity. Dr. Halcomb noted that imaging studies showed spinal stenosis at L4-S1, with a" dynamic instability with changing in position producing a change in the degree of encroachment." He recommended decompression and pedicle screw fusion and fixation. Dr. Halcomb opined that appellant was "not suitable to return to gainful employment" and "should be considered disabled from the time of [his] initial evaluation, June 14, 1994 through the present and continuing for the indefinite future."

In a February 14, 1995 report, Dr. Don W. Vanderpool, an Office medical adviser, reviewed the medical record and statement of accepted facts He opined that the proposed decompression and fusion for spinal lumbar stenosis was related to the accepted condition. "The fall apparently aggravated a preexisting condition" leading to "symptomatic spinal stenosis" with lumbar and leg discomfort aggravated by activity. Dr. Vanderpool stated that Dr. Halcomb's proposed fusion with pedicle screw fixation was not "accepted medical practice" as appellant did not have "degenerative spondylolisthesis or spinal fracture." On February 16, 1995 the Office authorized surgical decompression.[4]

In a June 17, 1995 report, Dr. Michael Gorum, a Board-certified neurosurgeon and second opinion physician, provided a history of injury and treatment and reviewed the medical record. On examination, Dr. Gorum found mild lumbar tenderness without restricted range of motion, normal muscle tone of the upper and lower extremities, voluntary restriction of left shoulder motion due to pain and negative straight leg raising tests bilaterally. He noted changes in pinprick sensation in a nondermatomal distribution near the left thumb and in the left foot. Dr. Gorum diagnosed mild cervical strain and left shoulder strain due to the January 23, 1994 fall, without objective neurologic findings. He noted radiographic findings of record indicative of mild to moderate degenerative cervical and lumbar disc disease, without objective evidence of

[3] June 14, 1994 x-rays showed degenerative cervical disc disease at C4-6 with mild straightening of the cervical lordosis. June 16, 1994 cervical myelogram and CT scans showed "mild foraminal encroachment at C4-5 and C5-6 on the left secondary to osteophytes," without evidence of a herniated nucleus pulposus or spinal stenosis." July 18, 1994 EMG and nerve conduction velocity studies of appellant's left upper extremity were within normal limits.

[4] In a February 24, 1995 report, Dr. Halcomb again recommended fusion, based on myelograms showing a "dynamic increase in the amount of spinal stenosis on extension in the upright position … reduced by flexion. This is in effect, degenerative spondylolisthesis." He submitted periodic reports through July 1995 recommending decompression and fusion, noting appellant's continuing symptoms.

neural compression. Dr. Gorum concluded that appellant's symptoms did not correlate with "physical examination findings" or radiographic data. Due to the lack of objective neurologic findings," he did not recommend either cervical or lumbar surgery.

In an August 1, 1995 letter, the employing establishment stated that appellant's date-of-injury position of telephone service representative involved sitting and "taking applications over the phone and writing the report by hand" for eight hours per day, with a 10-minute break in the morning and afternoon, and a 30-minute lunch break.

In a September 12, 1995 report, Dr. Halcomb noted that appellant's degenerative disc disease caused "considerable pain impacting upon her activities of daily living."[5]

In an October 9, 1995 report, Dr. Gorum noted reviewing the statement of accepted facts and questions for determination. Dr. Gorum opined that appellant had residuals of neck, arm, back and leg pain requiring "nonsteroidal anti-inflammatory drugs, and occasional physical therapy. [Appellant] does not have any objective neurologic findings related to the incident." Dr. Gorum stated that while appellant's symptoms had remained similar since January 23, 1994, the injury "should have by this time run [its] course." He opined that the telephone service representative position did not require "any activity significantly exacerbating [appellant's] medical condition." Dr. Gorum concluded that appellant had reached maximum medical improvement, and could expect occasional neck and back pain related to arthritis, treatable with nonsteroidal anti-inflammatory drugs.

By notice dated November 22, 1995, the Office advised appellant that it proposed to terminate her compensation benefits as the medical evidence indicated that she was no longer totally disabled from her date-of-injury job. The Office noted that Dr. Gorum found no objective neurologic findings or evidence of neural tissue compression, and opined that the telephone service representative position would not aggravate appellant's condition.

In a November 28, 1995 letter, appellant objected to the proposed termination of compensation, asserting that Dr. Halcomb had found her totally disabled for work and that she could not perform the duties of a telephone service representative due to neck and back pain. Appellant noted that Dr. Gorum spent only 20 minutes examining her and asserted that this was insufficient to understand her condition.

By decision dated December 20, 1995, the Office terminated appellant's compensation effective December 9, 1995 on the grounds that the weight of the medical evidence, as represented by Dr. Gorum, established that appellant was capable of performing her date-of-injury job. The Office stated that Dr. Halcomb provided insufficient objective findings and medical rationale to establish that appellant was disabled from her job as a telephone service representative on and after December 9, 1995 due to residuals of the January 23, 1994 injury.

[5] In a September 20, 1995 file note, the Office noted that Dr. Halcomb had advised an Office rehabilitation nurse assigned to appellant's case that appellant could return to her date-of-injury job as of that day. In a November 11, 1995 report, Dr. Halcomb related appellant's symptoms of anterior and posterior neck pain with headaches.

The Board finds that the Office did not meet its burden of proof in terminating appellant's compensation benefits. Therefore, the case is not in posture for a decision because of a conflict of medical opinion between Dr. Halcomb, appellant's attending orthopedic surgeon and Dr. Michael Gorum, a Board-certified neurosurgeon and second opinion physician, for the government.

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation benefits. 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.[6]

In the present case, the Office accepted that appellant sustained cervical, lumbar, thoracic, wrist and right shoulder strains, and bilateral knee contusions in a January 23, 1994 fall. The Office, therefore, has the burden of proof to justify termination of compensation for disability resulting from those conditions.

Appellant's attending physician, Dr. Halcomb, an orthopedic surgeon, supported appellant's continuing disability in a series of reports, although he did not submit evidence of record directly addressing the period beginning December 9, 1995. In December 23, 1994 reports, he opined that appellant was not able to "return to gainful employment," and "should be considered disabled" indefinitely from June 14, 1994 onward. In a September 12, 1995 report, Dr. Halcomb noted that appellant's degenerative disc disease caused pain "impacting upon her activities of daily living."

In his June 17 and October 9, 1995 reports, Dr. Gorum opined that appellant had no work-related disability after October 9, 1995, although she did have residuals of neck, arm, back and leg pain.

Thus, there was a conflict of medical opinion evidence regarding whether appellant continued to be disabled for work due to the accepted injuries on and after December 9, 1995. Due to the conflict in medical opinion, the record as a whole was equivocal on the critical issue of the causal relationship between appellant's claimed continuing disability for work and the accepted January 23, 1994 injuries. Therefore, the Office did not have a sufficient basis on which to terminate appellant's compensation.

The case should be returned to the Office for payment of appropriate retroactive compensation benefits and reinstatement on the appropriate compensation rolls.

The decision of the Office of Workers' Compensation Programs dated December 20, 1995 is hereby reversed.

Dated, Washington, D.C.
October 6, 1998

[6] *Jason C. Armstrong*, 40 ECAB 907 (1989).

David S. Gerson
Member

Bradley T. Knott
Alternate Member

A. Peter Kanjorski
Alternate Member