U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of LA ROSA L. HARRIS and DEPARTMENT OF DEFENSE, DEFENSE GENERAL SUPPLY CENTER, Richmond, Va.

Docket No. 97-2403; Submitted on the Record;
Issued April 28, 1999

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON, BRADLEY T. KNOTT

The issue is whether the Office of Workers' Compensation Programs met its burden of proof to terminate benefits on April 27, 1996.

The Office accepted appellant's claim for cervical and lumbar disc herniation and surgery for C4-5 and C5-6 anterior cervical discectomy and fusion which was performed on September 28, 1995. Appellant had injured her back at work on July 24, 1995 and has not worked since the injury. The Office terminated appellant's compensation benefits by decision dated April 26, 1996 on the grounds that the weight of the medical evidence demonstrated that the injury-related disability had ceased.

In a report dated February 16, 1996, Dr. Alfred P. Magness, appellant's treating physician and a Board-certified neurological surgeon, performed a physical examination, found that appellant's back pain was "not severe" and opined that she could return to light-duty work with a 10-pound lifting restriction.

In a report dated March 1, 1996, Dr. Magness opined that appellant stated that appellant was complaining of pain in her entire back including her neck and her low back and that he was keeping her out of work because she was complaining of so much pain.

In a report dated March 29, 1996, Dr. Magness opined that appellant had satisfactory strength and a chronic disc herniation and opined that she was totally disabled.

In a report dated February 28, 1996, Dr. John S. Wagner, a Board-certified orthopedic surgeon and second opinion physician, considered appellant's history of injury, performed a physical examination, and reviewed x-rays taken at the time of appellant's July 24, 1995 employment injury showing degenerative changes at the C4-5 and C5-6 levels and new x-rays showing surgical changes at those levels. The lumbar spine x-rays were normal. He also reviewed x-rays dated August 7, 1995 which showed, in part, moderately advanced degenerative

disc disease from C2-3 through C6-7 and spondylolysis with anterior an osteophyte and disc space degeneration of C5-6 with narrowing. Further, Dr. Wagner reviewed a magnetic resonance imaging (MRI) scan of the cervical spine dated October 13, 1994 which showed two disc herniations at C4-5 and C5-6, and when repeated showed the same disc herniations and a lumbar MRI scan dated September 1, 1995 which showed disc herniation at L5-S1. Dr. Wagner stated:

> "I feel [appellant's] symptomatology, even though her orthopaedic exam[ination] was fairly normal, does have a preexisting condition with marked degenerative changes of her cervical spine. It is very difficult to ascertain whether [appellant's] neck condition was aggravated simply by using a scanner weighing 1 and ½ pounds from a bent position going into a standing position. I have difficulty ascertaining that this caused cervical damage. If it did, this damage should have resolved over a three[-] to four[-]month period of time. At this time, apparently [appellant] is doing well from her low back and her examination does not reveal any indication to go ahead with L5-S1 surgery."

He stated that appellant could return to full-time work and had reached maximum medical improvement.

On May 21, 1996 appellant requested an oral hearing before an Office hearing representative which was held on February 27, 1996. At the hearing, appellant described her injury and her symptoms of pain in her back and neck which severely limit her activities. She stated that she was still taking medication, receiving medical treatment and wished to undergo surgery. Appellant also submitted additional medical evidence consisting of reports from Dr. Magness dated from June 28, 1996 through February 5, 1997 and a report from Dr. Timothy E. Budorick, a Board-certified orthopedic surgeon, dated June 3, 1996. In his October 10, 1996 report, Dr. Magness stated that appellant continued to have pain in her neck and a ruptured lumbar disc. He stated that he kept appellant out of work due to her chronic, severe complaints of pain. In his December 4, 1996 and February 5, 1997 reports, he noted that appellant would like to proceed with surgery pending the Office's approval and stated in his February 5, 1997 report that "[n]eurologically, appellant appears to have reasonably good strength and can ambulate easily." Dr. Magness noted appellant's complaints of pain in her back, both legs and left arm.

In his June 3, 1996 report, Dr. Budorick considered appellant's history of injury and performed a physical examination which showed "somewhat limited" rotation and flexion and extension and remarkable strength in her upper and lower extremities. He stated that appellant did not have symptoms which correlated clearly with a pain pattern and no neurological findings consistent with her complaints of pain. Dr. Budorick stated he would like to see further diagnostic tests performed as in an MRI scan or computerized tomography (CT) myelogram or electromyogram, that a "neurology" opinion might be helpful, and that he was concerned about the psychological overlay and behavioral overlay in appellant's situation.

By decision dated April 24, 1997, the Office hearing representative affirmed the Office's April 26, 1996 decision.

The Board finds that the Office has not met its burden of proof to terminate benefits.

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 disabling condition has ceased or that it is no longer related to the employment.[1] The Office's burden of proof includes the necessity of furnishing rationalized medical evidence based on a proper factual and medical background.[2]

In the present case, a conflict exists between the opinion of appellant's treating physician, Dr. Magness, that appellant is totally disabled due to her back and neck pain and requires surgery and the opinion of Dr. Wagner, a second opinion physician, that appellant is capable of returning full time to her usual work and did not require surgery. While Dr. Magness relies on appellant's complaints of pain in making his disability assessment in his reports dated from March 1, 1996 through February 5, 1997, he also notes that appellant has lumbar disc herniation which is supported by the September 1, 1995 lumbar MRI scan identified in Dr. Wagner's report and was an accepted condition. Dr. Wagner's February 28, 1996 report is not well rationalized because, while Dr. Wagner stated that appellant's orthopedic examination was fairly normal, the October 13, 1994 MRI scan showed two cervical disc herniations and the September 1, 1995 MRI scan showed a lumbar disc hernation but Dr. Wagner does not explain whether the three herniations have any impact on appellant's ability to work and whether they were related to appellant's federal employment.

As the conflict between Drs. Magness and Wagner regarding the nature and extent of appellant's disability remains unresolved, the Board will reverse the April 24, 1997 decision of the Office.

[1] *Patricia M. Mitchell*, 48 ECAB ___ (Docket No. 95-384, issued February 27, 1987); *Patricia A. Keller*, 45 ECAB 278 (1993).

[2] *Larry Warner*, 43 ECAB 1027 (1992); *see Del K. Rykert*, 40 ECAB 284, 295-96 (1988).

Accordingly, the decision of the Office of Workers' Compensation Programs dated April 24, 1997 is hereby reversed.

Dated, Washington, D.C.
April 28, 1999

George E. Rivers
Member

David S. Gerson
Member

Bradley T. Knott
Alternate Member