U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of KAREN THORNTON and DEPARTMENT OF VETERANS AFFAIRS, MEDICAL CENTER, Decatur, GA

Docket No. 97-2867; Submitted on the Record;
Issued August 9, 1999

DECISION and ORDER

Before DAVID S. GERSON, MICHAEL E. GROOM,
BRADLEY T. KNOTT

The issue is whether the Office of Workers' Compensation Programs properly terminated appellant's compensation benefits for the employment injury she sustained on November 22, 1995.

On November 22, 1995 appellant, a program support assistant, sustained an injury while in the performance of her duties when an overhead modular desk door struck her on the head. She was diagnosed with a closed head injury, post-traumatic tension type headaches and memory impairment. The Office accepted the condition of head contusion. Additional medical evidence offered psychiatric diagnoses of post-traumatic stress disorder and brief psychotic disorder, rule out amnestic disorder. The Office advised appellant that it also accepted her claim for the condition of closed head injury and placed her on the periodic compensation rolls.

Upon further development of the evidence, the Office found that conflict in medical opinion existed between appellant's attending physicians -- Dr. Anthony B. Michaels, an osteopathic physician and diplomat, American Board of Psychiatry and Neurology, and Dr. Arnold Weingarden, a consulting clinical psychologist -- and the Office referral physician, Dr. W. John Baker, a clinical neuropsychologist. On January 17, 1996 Dr. Michaels reported that appellant had a closed head injury, organic affective disorder, amnesic disorder, cervical strain and organic psychosis causally related to the work incident of November 22, 1995. He indicated that she was totally disabled for work. On or about February 9, 1996 Dr. Weingarden reported that the diagnosis most consistent with appellant's current functional psychopathology was schizophreniform disorder in a hysteroid setting. He stated that a review of possible etiologies was consistent with appellant's clinical presentation and the examination findings indicating that she sustained a traumatic brain injury when she was injured at work in November 1995. Secondary psychotic pathology developed, he stated, due to the strain on her premorbid personality, which lacked resilience. Dr. Weingarden reported that appellant was disabled for all work.

On May 22, 1996 Dr. Baker listed as his principal diagnosis probable malingering. He also diagnosed likely histrionic or dependent personality disorder. Dr. Baker could find no convincing evidence to support an interpretation of brain damage in appellant's case. He stated that the history provided suggested that, at the very most, appellant might have sustained a minimal concussion, which does not cause brain damage. Cognitive symptoms growing over time and the amnesia described and presented were inconsistent with an organic condition but reflected a psychiatric condition. Dr. Baker could find no reason to identify appellant as disabled. He stated that the incident did not appear to him to be sufficient to result in any psychological problems. He reported that he could find no basis for appellant's subjective psychological or psychiatric complaints.

Dr. Weingarden reported on July 14, 1996 that a closed head injury was a phenomenon that was within the purview of psychiatry and psychology as well as medicine. Sometimes, he explained, such an injury involves apparently purely medical issues such as headaches, dizziness and seizure disorders. Sometimes, despite there being tissue damage, the consequences of the injury are most notably psychological, that is, cognitive, mental and emotional disturbances. Dr. Weingarden stated that the physical sequelae of appellant's closed head injury had abated but not completely cleared by the time of his examination in January and February 1996 and that a strong suspicion of psychological sequelae existed.

To resolve this conflict in medical opinion, the Office referred appellant to Dr. Eric C. Amberg, a Board-certified forensic examiner, who reported on July 19, 1996 that he did not see any causal relationship between the incident with the overhead door and the symptoms presented.

To help determine whether appellant continued to suffer from physical residuals of the accepted head contusion and closed head injury, the Office referred appellant, together with the medical file and a statement of accepted facts, to Dr. Lawrence M. Eilander, a Board-certified specialist in internal medicine and neurology. On September 18, 1996 Dr. Eilander reported that appellant probably suffered a concussion at work in November 1995 and might have suffered from post-traumatic headaches, but usually these vary in intensity throughout the day and appellant's were relatively constant, which was very atypical for post-traumatic headaches. Dr. Eilander stated that clinically he did not feel that appellant suffered a major closed head injury at the time of the incident because of the neuropsychometric testing and her general neurological examination. In actuality, he noted, appellant's processing time was not slowed at all, which was something he observed in almost every single head injury patient over the years. Abnormalities on the positron-emission tomography (PET) scan might or might not be related to trauma to the head; it was very controversial, he stated, whether a PET scan would give further information on whether appellant suffered a traumatic brain injury. Dr. Eilander concluded: "I feel that the majority of this patient's symptoms are psychiatrically mediated and I do not feel that she is disabled from a neurologic aspect."

Dr. Michaels continued to diagnose closed head injury together with organic affective disorder, which he attributed to the incident in November 1995. On August 28, 1996 he noted that the correct diagnoses for appellant were closed head injury and head concussion, brief psychosis -- resolved, amnesiac disorder -- resolved, organic affective disorder -- depressed and

anxious and paresthesia of the scalp, all of which he stated had been thoroughly and repeatedly documented. In a report dated January 27, 1997, Dr. Michaels gave as his principal diagnoses organic affective disorder, depression, anxiety, panic and post-traumatic stress disorder. He listed general medical conditions as closed head injury/post-concussive syndrome, complex cephalgia, chronic cervical strain and rule out crush injury scalp neuropathy. Dr. Michaels stated that by the time Office referral physicians tested appellant, signs of head injury had improved and that the psychotic features were related to premorbid states but clearly had deteriorated after appellant's injury. He reported that appellant would be hospitalized for continued follow-up and brief restabilization.

In a decision dated August 14, 1997, the Office affirmed the termination of appellant's compensation benefits on the grounds that the weight of the medical evidence, as represented by the opinions of the Office referral physicians, including an impartial medical specialist, established that appellant had recovered from the effects of her November 22, 1996 employment injury by October 28, 1996.

The Board finds that the Office properly terminated appellant's compensation benefits for the physical sequelae of the accepted conditions of head contusion and closed head injury.

It is well established that, 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]

The weight of the medical evidence in this case supports the Office's termination of compensation benefits effective October 28, 1996 for the physical sequelae of the accepted conditions of head contusion and closed head injury. Dr. Baker stated that the history provided suggested that, at the very most, appellant might have sustained a minimal concussion, which does not cause brain damage. In August 1996 Dr. Michaels clarified that the correct diagnoses for appellant included a head concussion. Dr. Eilander reported that appellant probably suffered a concussion at work in November 1995. While such reports tend to support a functional component to the injury appellant sustained on November 22, 1995, none supports continuing organic residuals of a contusion.

With respect to physical residuals of the accepted closed head injury, the most probative report is that of Dr. Eilander. On September 18, 1996 he reported that the majority of appellant's symptoms were psychiatrically mediated and that she was not disabled from a neurologic aspect. Dr. Eilander supported this opinion by explaining that appellant's headaches, which were relatively constant throughout the day, were very atypical of post-traumatic headaches. Clinically, he felt that appellant did not suffer a major closed head injury given her neuropsychometric testing and general neurological examination and appellant's processing time

[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).

was not slowed at all, which was something he had observed in almost every single head injury patient over the years. Abnormalities on the PET scan, he indicated, were not very insightful. Dr. Eilander's opinion is reasoned, is based on an accurate factual and medical history and comes from a specialist in the appropriate field. Further, his opinion appears consistent with statements from Dr. Michaels, who noted that by the time Drs. Baker and Amberg had tested appellant in May and July 1996, signs of head injury had improved and from Dr. Weingarden, who reported that the physical sequelae of appellant's closed head injury had abated but not completely cleared by the time of his examination in January and February 1996. As the weight of the medical evidence supports that the neurological residuals of the closed head injury resolved by October 28, 1996, the Board will affirm the Office's August 14, 1997 decision on the issue of physical sequelae.

The Board will remand the case, however, for proper development of the medical evidence on whether the employment incident of November 22, 1995 caused or contributed to a psychological or psychiatric condition.

The Office's procedure manual provides that where a conflict has arisen between a psychologist and a psychiatrist, the Office will obtain an impartial medical examination from a psychiatrist.[3] The Office failed to follow this procedure when it sought an impartial medical examination from Dr. Amberg to resolve a conflict between Drs. Michaels and Baker who disagreed on whether the incident of November 22, 1995 resulted in any psychological condition. The Board will set aside the Office's August 14, 1997 decision on the issue of psychological or psychiatric or functional sequelae and remand the case for an impartial medical examination and a well-reasoned opinion from an appropriate psychiatrist. After such further development of the evidence as may be necessary, the Office shall issue an appropriate final decision on this aspect of appellant's claim.

[3] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Medical Examinations*, Chapter 3.500 (March 1994).

The August 14, 1997 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part. The case is remanded for further action consistent with this opinion.[4]

Dated, Washington, D.C.
August 9, 1999

David S. Gerson
Member

Michael E. Groom
Alternate Member

Bradley T. Knott
Alternate Member

[4] In view of the Board's disposition of this appeal, the motion to affirm in part and remand in part filed by the Director of the Office on April 29, 1999 is rendered moot.