U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of VIVIAN A. ALEXANDER and U.S. POSTAL SERVICE, POST OFFICE, Pasadena, TX

Docket No. 99-1534; Submitted on the Record; Issued March 7, 2000

DECISION and ORDER

Before MICHAEL J. WALSH, GEORGE E. RIVERS, DAVID S. GERSON

The issue is whether the Office of Workers' Compensation Programs met its burden of proof to terminate appellant's compensation benefits effective December 15, 1997.

The Board has duly reviewed the case on appeal and finds that the Office met its burden of proof to terminate appellant's compensation benefits.

On October 8, 1968 appellant, then a 40-year-old registry clerk, filed a claim for traumatic injury alleging that, on October 8, 1968, she injured her back and hips while dispatching rotary lock pouches. The Office accepted appellant's claim for back sprain and aggravation of preexisting spondylolisthesis. Appellant worked intermittently, suffering several recurrences of disability from January 9, 1969 until September 3, 1975, when she stopped work and did not return. In a letter dated October 31, 1997, the Office proposed to terminate appellant's compensation benefits. Appellant did not submit any additional medical evidence in response to the notice. By decision dated December 15, 1997, the Office terminated appellant's compensation and medical benefits beginning December 15, 1997. The instant appeal follows.

Once the Office accepts a claim, it has the burden of proving that the disability has ceased or lessened to order 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.[3] To

[1] *Mohamed Yunis*, 42 ECAB 325, 334 (1991).

[2] *Id.*

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

terminate authorization for medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition which require further medical treatment.[4]

In this case, on February 3, 1984, when it became apparent to the Office that appellant was no longer being seen by her treating physician, Dr. H.L. Brannan, the Office referred appellant to Dr. R. Louis Gavioli, a Board-certified orthopedic surgeon, to obtain an updated picture of appellant's health. In his initial report dated February 21, 1984, Dr. Gavioli documented his findings on examination and testing, noting that x-rays showed an increased lumbar lordosis and evidence of degenerative disc disease, but did not reveal any spondylolysis and certainly did not reveal any spondylolisthesis. He stated that appellant probably had a herniated lumbar disc with right lumbar radiculopathy in addition to having developed degenerative disc disease in her lumbar spine. In response to the Office's inquiry as to whether appellant continued to suffer from an employment-related aggravation of her preexisting spondylolisthesis, Dr. Gavioli stated that he did not believe appellant had spondylolisthesis, but felt she probably had a herniated disc and now had degenerative disc disease, and was permanently disabled. Appellant continued to see Dr. Gavioli on an annual basis in keeping with the requirements of the Office that she submit periodic medical reports, but she declined to consent to any diagnostic testing or treatment. In his final report of record, dated July 15, 1991, Dr. Gavioli diagnosed probable spinal stenosis with progressive neurologic deficits in the lower extremities and concluded that appellant undoubtedly had permanent total disability. The physician stated that he would not continue to see appellant, as she refused treatment, and only came for visits in order to continue to qualify for compensation.

As appellant had submitted no medical reports subsequent to Dr. Gavioli's 1991 report, on August 8, 1997 the Office referred appellant, together with a statement of accepted facts,[5] the medical opinions of record and a list of issues to be addressed, to Dr. Charles R. Hand, a Board-certified orthopedic surgeon, for a second opinion examination. In his report dated September 18, 1997, Dr. Hand noted that appellant was extremely obese and reported that she had been essentially bedridden since 1975. He stated that he was unable to do a complete back examination, as appellant complained bitterly of pain throughout the examination, and refused to even attempt several diagnostic maneuvers she felt could be too painful. Dr. Hand stated that five x-ray views of the lumbosacral spine were obtained which revealed osteoporosis with some narrowing of the L3-4 disc space. He also noted that there was some degenerative arthrosis throughout, but that appellant had apparent good disc spaces at the L4 and L5 levels. Specifically, Dr. Hand found no evidence of spondylosis and "certainly, no spondylolisthesis as previously reported." Dr. Hand further noted that a computerized tomography (CT) scan taken on October 18, 1996 revealed that at L3-4 and L4-5, there is diffuse posterior disc bulge with degenerative apophyseal disease resulting in at least moderate spinal canal stenosis, and probably borderline neural foraminal stenosis. He added that at L5-S1, there is extensive degenerative apophyseal disease, greater of the right than on the left with an associated vacuum

[4] *Id.*

[5] The statement of accepted facts sent to Dr. Hand indicated that the Office had accepted back strain and aggravation of preexisting spondylosis. However, the nonfatal summary, and earlier documents in this claim indicated that the Office accepted aggravation of preexisting spondylolisthesis. As Dr. Hand addressed both conditions in his report, any mistake on the part of the Office is harmless.

phenomenon on the right. He concluded that at this level testing showed no focal disc protrusion or spinal canal stenosis and borderline neural foraminal stenosis bilaterally. Dr. Hand listed his impression as spinal stenosis with extreme obesity, hypertension and diabetes (by history). Dr. Hand discussed appellant's condition, stating:

> "This patient's examination was very difficult because of her extreme obesity and her inability or unwillingness to cooperate fully during the examination. I believe that she does have objective evidence of spinal stenosis on the CT scan. I believe that for practical purposes, she is completely and permanently disabled and is an unemployable individual. I am unable to say what condition her back would be in today if she had not suffered the described strain in her back in 1968. These muscle strains usually resolve within a few weeks or months. I see no evidence of spondylosis."

Dr. Hand concluded that appellant could hardly walk due to a combination of her back pain, her age and her obesity and certainly could not do any type of work.

By letter dated October 9, 1997, the Office requested that Dr. Hand clarify his opinion as to whether appellant had "any residuals of the back strain from the injury at work on October 8, 1968. In a letter of response dated October 14, 1997, Dr. Hand responded that he did not believe appellant had any such residuals.

The Board finds that the weight of the medical opinion evidence rests with Dr. Hand's well-rationalized narrative report. Dr. Hand provided a history of injury, appellant's medical history, including reviewing the results of recent x-rays and a computerized tomography scan, as well as performing a physical examination. He noted that there was no evidence on x-ray or CT scan that appellant had spondylolisthesis or spondylosis, and stated in his follow-up report that he believed appellant's 1968 back strain had resolved without residuals. Although Dr. Hand found appellant to be totally disabled due to a combination of her back pain, obesity and age, his report also establishes that appellant's current condition is not due to her accepted employment injuries. In addition, Dr. Hand's report is consistent with the earlier reports from Dr. Gavioli, who also found no evidence of either spondylosis or spondylolisthesis.

As there is no other medical evidence of record which contradicts the report of Dr. Hand, the Office met its burden of proof to terminate appellant's compensation benefits.

The decision of the Office of Workers' Compensation Programs dated December 15, 1997 is hereby affirmed.

Dated, Washington, D.C.
March 7, 2000

Michael J. Walsh
Chairman

George E. Rivers
Member

David S. Gerson
Member