U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of CAROL ROTHER and DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Wilkes-Barre, PA

Docket No. 00-1181; Submitted on the Record;
Issued March 13, 2001

DECISION and ORDER

Before MICHAEL J. WALSH, MICHAEL E. GROOM, PRISCILLA ANNE SCHWAB

The issue is whether the Office of Workers' Compensation Programs properly terminated appellant's compensation.

On March 4, 1998 appellant, then a 53-year-old licensed practical nurse, was reaching for a file when her chair tipped over and she fell, landing on her left side. She indicated that she had pain from her left knee to her neck, in her back and in her right arm from the elbow to the fingers. The Office accepted appellant's claim for contusions, and muscle spasms and tendinitis of the left shoulder. She received continuation of pay for intermittent periods through June 9, 1998. The Office began payment of temporary total disability compensation effective June 10, 1998.

In a July 1, 1999 decision, the Office terminated appellant's compensation effective July 16, 1999 on the grounds that the weight of the medical evidence established that the injury-related disability had ceased. In a July 20, 1999 letter, she requested a hearing before an Office hearing representative which was conducted on November 15, 1999. In a December 21, 1999 decision, the Office hearing representative found that the Office had met its burden of proof in terminating appellant's compensation.

The Board finds that the Office met its burden of proof in terminating appellant's compensation.

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.[1]

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

In a May 26, 1998 report, Dr. Ronald L. Richterman, a Board-certified radiologist, stated that a magnetic resonance imaging (MRI) scan of the cervical spine showed mild degenerative changes at the C5-6 level with mild symmetric impingement on the anterior aspect of the thecal sac.

In a May 6, 1998 office note, Dr. Martin D. Blidner, a Board-certified rheumatologist, diagnosed cervical strain, trapezius strain, myofascial pain syndrome, rhomboid tendon strain, strain of the sacroiliac joint and rheumatoid arthritis. In an August 16, 1998 report, he stated that appellant was being treated for a myofascial pain syndrome involving her neck, left shoulder, upper back and trapezius region. Dr. Blidner indicated that physical examination revealed mid-trapezius spasm associated with significant tenderness. He also found tenderness along the posterior cervical spine and rhomboid region with decreased motion of the cervical spine. Dr. Blidner noted pain on abduction of the left shoulder to 45 degrees. He concluded that appellant was unable to return to work and related the restrictions of appellant's work activity to the employment injury.

In a May 20, 1998 office note, Dr. Nancy Gilhooley, a family practitioner, diagnosed cervical strain with trapezius strain and myofascial pain syndrome. In an August 20, 1998 report, she indicated that she saw appellant on March 4, 1998 with a history of falling off a stool. Dr. Gilhooley related that appellant complained of pain in the left arm, shoulder and hip and in the right arm and hand. She found tenderness in all these areas. Dr. Gilhooley noted that x-rays were normal. She diagnosed contusions at that time. Dr. Gilhooley stated in a July 21, 1998 examination that appellant was not having any significant improvement with her pain. At that time she diagnosed myofascial pain syndrome with resultant headaches and referred her for physical therapy.

The Office referred appellant, together with a statement of accepted facts and the case record, to Dr. Stanford B. Sternlieb, a Board-certified orthopedic surgeon, for an examination and second opinion. In an October 8, 1998 report, he indicated that on examination appellant's cervical spine movements were variable, noting that she could follow his movement around the examination room but, when asked to perform range of motion, indicated that she could not perform any rotation of her neck and could perform only limited flexion. Dr. Sternlieb suggested that appellant showed evidence of symptom exaggeration. He found no paravertebral muscle spasm or tenderness in the neck.

Dr. Sternlieb also indicated that there were some questions of appellant's cooperation with movement of the left shoulder. He stated that, on elevation of the left arm, appellant showed 75 to 80 degrees of flexion and abduction but the movement was not accompanied by any disturbance of the scapulohumeral rhythm. Dr. Sternlieb commented that it was unusual to have the restriction in motion without any symptomatology referable to the shoulder. He found no sensory, motor or pulse deficit. Dr. Sternlieb reported that the Phalen's and Tinel's tests were negative. He stated that appellant had no evidence of muscle weakness or atrophy.

Dr. Sternlieb concluded that appellant had recovered from her contusions, the muscle spasm of her shoulder and tendinitis of the left shoulder with no evidence of a residual. He found no objective evidence of any abnormality. Dr. Sternlieb indicated that appellant had preexisting degenerative changes of the cervical spine which were a normal part of the aging

process and not due to the employment injury. He also noted that appellant had preexisting rheumatoid arthritis and residual of an injury of the flexor tendons of the right index finger.

Dr. Sternlieb stated that the period of disability would have terminated within three months. He opined that appellant had no physical limitations caused by the March 4, 1998 employment injury.

In a November 20, 1998 report, Dr. Gilhooley indicated that she disagreed with Dr. Sternlieb's report. She stated appellant, on her examination, had objective evidence of abnormalities which included spasm in the area of her pain. Dr. Gilhooley noted that appellant had worked for several years despite a diagnosis of rheumatoid arthritis. She reported that appellant currently had pain with any movement of her neck or elevation of her arm. Dr. Gilhooley diagnosed a myofascial pain syndrome secondary to the employment injury which had become a chronic condition.

The Office found a conflict in medical opinion and referred appellant, together with a statement of accepted facts and the case record, to Dr. Joseph R. Sgarlat, a Board-certified orthopedic surgeon, for an impartial examination.

In a May 3, 1999 report, Dr. Sgarlat noted that appellant reported her pain began on the left side of the neck and extended through the left shoulder and down the left arm with severe pain and paresthesias. He indicated that appellant's complaints of tenderness left him unable to touch her without a withdrawal type of reaction. Dr. Sgarlat commented that the response appeared to be grossly exaggerated as the areas of her complaints showed no objective abnormalities. He found no spasm in the muscles of the neck, shoulder or arm, no atrophy in the left arm, and normal tendon reflexes. Dr. Sgarlat stated that appellant voluntarily restricted motion of her left arm, particularly of the left shoulder, which did not correspond to objective findings. He commented that no use of the shoulder would produce atrophy of the shoulder girdle muscles but he found no atrophy. Dr. Sgarlat indicated that appellant voluntarily limited the motion of her neck, noting that he found no muscle spasm that would limit her movements.

Dr. Sgarlat concluded that appellant's injuries from the March 4, 1998 employment injury consisted of contusions of the hips, knees and left shoulder. He indicated that the complaints of pain radiating from the neck to the left shoulder and left arm were unsupported by any objective evidence except for mild degenerative changes at one level in the cervical spine which he regarded as a preexisting condition. Dr. Sgarlat stated that appellant would have normally recovered from her contusions in three months at most. He concluded, therefore, that appellant had recovered from her March 4, 1998 employment injury. Dr. Sgarlat indicated that he would place no restrictions on her physical activities that would relate to that injury.

In situations where there exist opposing medical reports of virtually equal weight and rationale, and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[2]

[2] *James P. Roberts*, 31 ECAB 1010 (1980).

In this case, Dr. Sgarlat, selected as an impartial medical specialist, gave a full description of his findings on examination of appellant and stated that she had no objective abnormalities that would support her symptoms. He noted only mild degenerative changes in the cervical spine which preexisted the employment injury. Dr. Sgarlat provided a fully-rationalized report, based on his findings on examination, to support his conclusion that appellant had no residuals from the conditions accepted by the Office as causally related to the employment injury. His report, therefore, is entitled to special weight and, in the circumstances of this case, constitutes the weight of the medical evidence. Dr. Sgarlat's report provides a sufficient basis for the Office's decision to terminate appellant's compensation.

The decisions of the Office of Workers' Compensation Programs, dated December 21 and July 7, 1999, are hereby affirmed.

Dated, Washington, DC
March 13, 2001

Michael J. Walsh
Chairman

Michael E. Groom
Alternate Member

Priscilla Anne Schwab
Alternate Member