U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of WALTER J. FISHER and DEPARTMENT OF THE NAVY, MARINE CORPS LOGISTICS BASE, Albany, GA

Docket No. 03-615; Submitted on the Record;
Issued May 22, 2003

DECISION and ORDER

Before COLLEEN DUFFY KIKO, DAVID S. GERSON, WILLIE T.C. THOMAS

The issues are: (1) whether the Office of Workers' Compensation Programs met its burden of proof to terminate appellant's wage-loss compensation effective November 16, 2001; and (2) whether appellant met his burden of proof to establish that he had any disability after November 16, 2001 causally related to his employment injury.

On January 2, 2001 appellant, then a 52-year-old procurement analyst, filed a claim for traumatic injury alleging that on December 18, 2000 he sustained a back injury in the performance of duty. On February 12, 2001 the Office accepted appellant's claim for thoracic, lumbar and sacral subluxations and subsequently expanded its acceptance to include a lumbar herniated nucleus pulposus at L3-4 with associated surgical correction. Appellant stopped work on December 21, 2000. On the advice of his physician, Dr. Edward W. Hellman, a Board-certified orthopedic surgeon, he returned to work half days on April 23, 2001 and returned to full duty on April 30, 2001.[1] Following appellant's return to work, however, he suffered psychiatric withdrawal symptoms after having been taken off his narcotic pain medication. Appellant stopped work again on August 22, 2001 due to his psychiatric symptoms. Appellant came under the care of Dr. William E. Coleman, a Board-certified psychiatrist, and his associate, Dr. Sasi K. Nayudu, both Board-certified psychiatrists. Appellant was hospitalized from September 14 to 17, 2001 and again from September 26 to October 23, 2001. In a report dated October 2, 2001, Dr. Coleman, appellant's treating Board-certified psychiatrist, explained that, following appellant's lumbar surgery, pain management was accomplished with oxycodone and hydrocodone preparations. In August 2001, appellant was switched from opiod analgesics to Tramadol. The physician stated that, shortly after this switch, appellant began manifesting severe symptoms of pain and disturbance of mood and thought, resulting in a prolonged hospitalization. Dr. Coleman stated that appellant's condition was viewed as a sequelae of his

[1] Although appellant's physicians actually released him to limited duty, with restrictions on lifting over 10 pounds and no frequent twisting or bending, the sedentary nature of his job enabled him to fully perform the duties of his date-of-injury position, despite these restrictions.

back injury and its treatment and that appellant would require extensive treatment and rehabilitation as an extension of his primary injury. The Office accepted appellant's claim for psychiatric withdrawal symptoms. In a joint report dated November 16, 2001, Drs. Coleman and Nayudu stated that, from a psychiatric standpoint, appellant seemed well enough to return to work, with no restrictions on carrying out his assigned duties.

By letter dated November 18, 2001, the Office informed appellant that it proposed to terminate his compensation, based on the earlier work release by his orthopedist, Dr. Hellman, and the November 16, 2001 joint report of his psychiatrists, Drs. Coleman and Nayudu. By decision dated January 23, 2002, the Office terminated appellant's wage-loss compensation benefits, effective November 16, 2001, on the grounds that his work-related disability had ceased as of that date. The Office noted that it recognized that appellant continued to have physical restrictions from his back injury and stated that while he was still entitled to medical treatment for his back condition, he was no longer entitled to wage-loss compensation because his physical restrictions did not prevent him from performing his full duties. In addition, the Office clarified that while it had accepted appellant's claim for psychiatric withdrawal symptoms following his switch in back pain medication and paid compensation through November 16, 2001, it had not accepted appellant's claim for any other psychiatric conditions and would not approve any continued psychiatric treatment. By letter dated March 27, 2002, the Office reiterated that it had not accepted appellant's claim for any consequential psychiatric conditions and informed appellant of the type of evidence necessary to meet his burden of proof to establish that any continued psychiatric treatment was employment related.

On April 2, 2002 appellant requested reconsideration and submitted additional evidence. In a July 24, 2002 merit decision, the Office denied modification of the prior decision. On September 6, 2002 appellant again requested reconsideration and submitted additional medical evidence. By decision dated October 11, 2002, the Office again denied modification of the prior decision. The instant appeal follows.

The Board finds that the Office met its burden of proof to terminate appellant's wage-loss compensation for his accepted back condition and accepted psychiatric reaction, effective November 16, 2001.

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation. After it has determined that an employee has disability causally related to his or her 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 medical evidence relevant to the termination of appellant's compensation includes an attending physician's report dated April 10, 2001 from his treating Board-certified orthopedic surgeon, Dr. Hellman, who diagnosed status post lumbar discectomy, advised that appellant could return to half days with restrictions for one week and then could resume full duty with restrictions on bending, lifting and twisting.[3] While appellant was taken off work again on

[2] *See Patricia A. Keller*, 45 ECAB 278 (1993).

[3] The employing establishment confirmed that appellant returned to work part-time on April 23, 2001 and resumed full duty on April 30, 2001.

July 16 to 25, 2001, due to complaints of increased back pain, in an attending physician's report dated August 1, 2001, Dr. Hellman stated that, while appellant continued to complain of recurrent back pain, repeat magnetic resonance imaging (MRI) scan performed on July 27, 2001 looked good, with no evidence of any type of recurrent herniation whatsoever and no evidence of nerve root impingement. Dr. Hellman released appellant back to work on August 6, 2001.

With respect to appellant's psychiatric condition, in a joint report dated November 16, 2001, Drs. Coleman and Nayudu, appellant's treating Board-certified psychiatrists, explained that on September 14, 2001 appellant was hospitalized for possible withdrawal from medications given for his prior back surgery. He was treated and discharged on September 17, 2001. On September 25, 2001 appellant presented as an outpatient and was diagnosed with major depression. Appellant was hospitalized on September 26, 2001 was transferred to another hospital facility on October 18, 2001 and was finally discharged on October 23, 2001. Drs. Coleman and Nayudu stated that appellant again presented on November 9, 2001 but appeared much better. The physicians stated that appellant's depression and possible withdrawal symptoms had greatly subsided since his first hospitalization and that his last visit showed significant improvement. They noted that he had been placed on pharmacotherapy, that his prognosis was good and that he seemed well enough to return to work with no restrictions. Drs. Coleman and Nayudu stated that, when dealing with depression as severe as appellant's, there is no assurance that some symptoms might not recur, but that with medication and regular checkups, he should remain under control.

In a report dated November 26, 2001, Dr. Coleman also recounted appellant's psychiatric history, noting that his condition manifested in August 2001, when a change in appellant's medication resulted in severe symptoms of pain and disturbance of mood and thought, resulting in prolonged hospitalization. Dr. Coleman stated that, as a result of appellant's physical problems and other health-related problems, he experienced severe depression and mood disorder. Appellant's depression began in September 2001 and progressed to a severe case by October 2001, necessitating medication and hospitalization to relieve appellant's symptoms and give him a new perspective. Dr. Coleman noted that, although he was no longer appellant's treating psychiatrist, his primary care having been taken over by a colleague,[4] recent contact with appellant indicated a patient free from the crippling and debilitating depression, for which he was treated in September and October 2001. Dr. Coleman concluded that appellant had been diagnosed with major depressive disorder, affective psychosis and hypertension.

In a follow-up report dated January 7, 2002, Dr. Nayudu stated that, subsequent to his prior November 16, 2001 letter, there had been a significant change in appellant's condition. The physician explained that appellant presented on the afternoon of December 10, 2001 and stated that he had attempted to return to work that morning, but had experienced a severe anxiety attack upon leaving home. Dr. Nayudu represcribed Klonopin, which had been previously discontinued and referred appellant to Dr. Nick Carden for counseling. Dr. Nayudu further noted that appellant had been experiencing severe headaches, but that their cause and appropriate treatment had yet to be determined.

[4] Dr. Nayudu, an associate of Dr. Coleman, became appellant's primary treating psychiatrist on October 26, 2001.

In a report dated December 10, 2001, Dr. Nayudu stated that he continued to treat appellant for depression, anxiety and headaches, but did not discuss the cause of any of these conditions.

The Board notes that, with respect to appellant's physical condition, although following his return to full duty on April 30, 2001, appellant was again taken off work for the period July 16 to 25, 2001, due to complaints of increased back pain, in his report dated August 1, 2001, Dr. Hellman, appellant's treating Board-certified orthopedic surgeon, stated that, while appellant continued to complain of recurrent back pain, repeat MRI scan performed on July 27, 2001 looked good, with no evidence of any type of recurrent herniation whatsoever and no evidence of nerve root impingement. Dr. Hellman released appellant back to work, with restrictions on August 6, 2001. Therefore, the Office properly terminated appellant's wage-loss compensation for his back claim, effective November 16, 2001, as the medical evidence establishes that appellant's disability for work causally related to his accepted back condition had ceased by that date.

With respect to his accepted psychiatric withdrawal symptoms following his switch in back pain medication, the psychiatric evidence of record, represented by the opinions of Drs. Coleman and Nayudu, appellant's treating Board-certified psychiatrists, establishes that appellant's psychiatric conditions had greatly subsided such that he was able to perform his full duties without restrictions. While Dr. Nayudu subsequently submitted a report indicating that appellant reported suffering an anxiety attack upon attempting to return to work on December 12, 2001, Dr. Nayudu did not explain the cause of appellant's anxiety attack, nor did he state that the attack had disabled appellant for work. Therefore, the Office properly terminated appellant's entitlement to wage-loss compensation benefits for his psychiatric withdrawal symptoms effective November 16, 2001, the date his treating psychiatrists released him to full duty. However, the right to medical benefits for an accepted condition is not limited to the period of entitlement to compensation for disability.[5] To terminate authorization for medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition, which require further treatment.[6] As Drs. Nayudu and Coleman stated in their November 16, 2001 report that appellant would require continued medication and regular checkups and as their opinions are uncontradicted, the Office improperly terminated appellant's entitlement to medical benefits for his accepted psychiatric reaction to his back pain medication.

The Board further finds that this case is not in posture for a decision on the issue of whether appellant established that he had an employment-related disability after November 16, 2001, causally related to his accepted physical or psychiatric conditions.

As the Office met its burden of proof to terminate appellant's compensation benefits, the burden shifted to him to establish that he had disability causally related to his accepted injury.[7]

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[5] *Beverly J. Duffey*, 48 ECAB 569 (1997); *Thomas Olivarez, Jr.*, 32 ECAB 1019 (1981).

[6] *Id; Furman G. Peake*, 41 ECAB 361 (1990).

[7] *See George Servetas*, 43 ECAB 424 (1992).

To establish a causal relationship between the condition, as well as any attendant disability claimed and the employment injury, an employee must submit rationalized medical evidence, based on a complete factual and medical background, supporting such a causal relationship.[8] The mere fact that a condition manifests itself or worsens during a period of employment does not raise an inference of an employment relationship. Neither the fact that the condition became apparent during a period of employment nor the belief of the employee that the condition was caused or aggravated by employment factors is sufficient to establish causal relation.[9] Causal relationship is a medical issue that can be established only by medical evidence[10] and the medical evidence required to establish a causal relationship is rationalized medical evidence. Rationalized medical evidence is medical evidence, which includes a physician's rationalized medical opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[11]

The medical evidence submitted subsequent to the January 23, 2002 decision, terminating appellant's wage-loss compensation effective November 16, 2001, includes a March 27, 2002 report, in which Dr. Nayudu attempted to explain appellant's condition and disability for work. He stated that there was an abundance of evidence in the medical community to support the contention that appellant's mental problems were correlated with his physical condition and the treatment he received for that condition. The physician noted that, as previously stated by Dr. Coleman in his November 26, 2001 letter, appellant's depression and mood disturbance were triggered by his work injury and medical condition. With respect to appellant's ability to return to work, Dr. Nayudu clarified that at the time of his January 7, 2002 letter, he considered appellant totally disabled for work purposes. Dr. Nayudu further stated:

> "My letter on 16 November 2001 was a collaborative effort with Dr. Coleman and [appellant]…. Although he still exhibited signs of depression and mood disorder, working may have been the best medicine for him. Apparently, this step was too big for him to take at that time. He relapsed into severe depression and began to experience intense headaches. This was not a new episode of any sort but a continuation of what he has been experiencing previously. Again, at this time his condition made him totally disabled from working in his job.
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> "Again, my letter of 7 January 2002 did not tie all of [appellant's] medical history together nor specifically state that he could not return to work due to the depression I was treating him for. I can state with assuredness that [appellant's] mental condition was triggered by his past physical problem and its treatment and should be connected, not treated as separate adventures…."

[8] *See* 20 C.F.R. § 10.110(a); *Kathryn Haggerty*, 45 ECAB 383 (1994).

[9] *Ruth C. Borden*, 43 ECAB 146 (1991).

[10] *Ruth C. Borden, supra* note 9; *Mary J. Briggs*, 37 ECAB 578 (1986).

[11] *Gary L. Fowler*, 45 ECAB 365 (1994); *Victor J. Woodhams*, 41 ECAB 345 (1989).

In an April 26, 2002 letter to Dr. Nayudu, the Office requested additional information regarding appellant's mental condition. The Office noted that appellant had a prior medical history of migraine syndrome, pineal cyst, hypertension, Wolff-Parkinson-White syndrome and prostatitis, in addition to his employment-related back injury sustained on December 18, 2000. The Office asked Dr. Nayudu to provide a rationalized medical opinion addressing appellant's migraine headaches, his need for hospitalization in September 2001 and whether appellant continued to suffer from a psychological condition, which was caused or aggravated by his December 18, 2000 employment injury.

In a response dated June 10, 2002, Dr. Nayudu stated:

> "[Appellant's] inpatient and outpatient tests were all negative concerning his headaches and neurological problems. There is n[o]t anything new to [appellant's] case that has not been explored in the documentation you already have. My conclusion is that [appellant's] headaches are most likely a result of anxiety and stress brought on by his work and health situations. The connection between his psychological problems and past medical problems is summed in Dr. Coleman's letter of 2 October 2001. His prolonged treatment for back pain using opiod analgesics and later change to Tramadol most likely caused his manifestations of severe pain and mood disturbance, resulting in later hospitalization. This hospitalization, most likely, played apart in the psychological problems he has experienced.
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> "[Appellant's] confusion or disorientation in September 2001 has no clear-cut causes. The change of medication could have precipitated this problem but no real evidence was present at the time to make any determination. His subsequent [December 10, 2001] panic attack seemed to be precipitated by the combination of the unknown origin of his headaches, inability to sleep and feeling of stress with his coworkers due to his absence from work.
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> "[Appellant's] psychological problems apparently began in September of 2001 with his [e]mergency [r]oom visit. At that time Dr. Coleman felt that [appellant] was totally disabled and unable to return to work. [Appellant's] determination to return to work was evident when he made the decision to try to return to work after his period of short-term stability. At that time I felt that his decision might be the best thing to help him overcome from his anxiety. Unfortunately, this was not to be as he had a severe panic attack in December, prior to returning to work.
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> "I understand that [appellant] has applied for retirement from the government and feel that if he is removed from this situation his symptoms will curtail. Coupled with his medication I feel that his prognosis is excellent. The cause of his headaches is still not known but I feel these may also dissipate with a resolution of the situation. There has been enormous pressure on [appellant] as he is trying to understand his medical problems, provide for and protect his family and to understand and work through the requirements involved in this situation."

In addition to the report from Dr. Nayudu, appellant submitted an August 25, 2001 medical report from Dr. Dinshaw Sidhwa of Phoebe Putney Memorial Hospital noting that appellant reported feeling nauseated, anxious and depressed after having take Ultram for the past three weeks. Dr. Sidhwa diagnosed a probable nonsteroidal anti-inflammatory drug reaction and side effects and advised appellant to flush his system with excessive water and juice and to visit his regular physician. Appellant also submitted hospital discharge summaries from Phoebe Putney Memorial Hospital pertaining to the periods September 14 to 17, 2001 and September 26 to October 18, 2001 and from Emory University Hospital pertaining to the period October 18 to 23, 2001. The Emory University discharge summary, completed by Dr. J. David Moore on October 24, 2001, notes that appellant was hospitalized approximately 38 years previously in a veterans hospital psychiatric ward for a nervous condition, which he was told was paranoid schizophrenia. Appellant reported to Dr. Moore that at that time he was placed on Thorazine and Mellaril, which he stopped upon his release from the hospital 30 years ago and that he has had no further psychiatric problems until 2001.

In a letter dated May 2, 2002, appellant confirmed that in 1969 he was treated for what was called a "nervous condition." He stated that he was hospitalized for a brief period of time in the Oakland Naval Hospital in Oakland California and in the Veterans Administration Hospital in Salisbury, North Carolina, but did not have any medical records pertaining to these periods of treatment. Appellant further stated that, while he did have a past history of migraine headaches, the headaches he had recently experienced were of a completely different type. Appellant submitted medical reports dated August 16 and September 17, 1999, from Dr. Josiah S. Matthews, who noted that appellant's severe migraine headaches were probably causally related to a brain cyst, which had been revealed on MRI scan.

Appellant also submitted a June 25, 2002 report from Dr. Carden, a clinical psychologist. He stated that appellant had been referred to him by Dr. Nayudu for counseling "related to post hospital care due to a psychotic episode that was apparently caused by a medication problem related to back surgery." Dr. Carden stated that appellant's psychological profile was consistent with clinical depression, anxiety and poor self concept and that appellant was not psychologically capable of working at that time."

Finally, appellant submitted a July 10, 2002 report from Dr. Nayudu, which is identical in all other respects to Dr. Nayudu's June 10, 2002 report.

The Board notes that, in his March 27, 2002 report, Dr. Nayudu clearly stated, "with assuredness that [appellant's] mental condition was triggered by his past physical problem and its treatment and should be connected, not treated as separate adventures…." In his June 10, 2002 report, Dr. Nayudu reiterated his belief, albeit not as vehemently, when he stated that appellant's prolonged treatment for back pain using opiod analgesics and later change to Tramadol "most likely" caused his manifestations of severe pain and mood disturbance, resulting in later hospitalization and that this hospitalization, "most likely," played apart in the psychological problems he has experienced. While the reports of Dr. Nayudu are not sufficient to establish that appellant's continuing disability is causally related to his employment injury and its sequelae, especially given the fact that the record contains evidence of a past psychiatric break, the Board notes that there is no contradictory evidence in the record and that Dr. Nayudu's reports are in general accord with the prior reports of Dr. Coleman.

Proceedings under the Federal Employees' Compensation Act[12] are not adversarial in nature, nor is the Office a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence to see that justice is done.[13] Although Dr. Nayudu's reports do not contain sufficient rationale to discharge appellant's burden of proving by the weight of the reliable, substantial and probative evidence that his disability and need for continuing psychiatric treatment after November 16, 2001, were causally related to his accepted employment-related back injury and his reaction to narcotic withdrawal, his reports raise an uncontroverted inference of causal relationship sufficient to require further development of the case record by the Office.[14] The Board will remand the case for further development of the medical evidence.

On remand, the Office should refer appellant, the case record and a statement of accepted facts to an appropriate medical specialist for an evaluation and a rationalized medical opinion on whether appellant's disability and need for psychiatric treatment after November 16, 2001 was causally related to his December 18, 2000 employment injuries and their treatment, either directly, or by precipitation, acceleration, or aggravation. After consideration of the specialist's opinion, together with all of the medical evidence which has been submitted by appellant in support of his claim and after such development of the case record as the Office deems necessary, a *de novo* decision shall by issued.

[12] 5 U.S.C §§ 8101-8193.

[13] *Jerry A. Miller*, 46 ECAB 243 (1994); *William J. Cantrell*, 34 ECAB 1223 (1983).

[14] *See John J. Carlone*, 41 ECAB 354 (1989); *Horace Langhorne*, 29 ECAB 820 (1978).

The decisions of the Office of Workers' Compensation Programs dated October 11 and July 24, 2002 are hereby set aside and the case remanded for further action consistent with this opinion. The decision of the Office dated January 23, 2002 is affirmed insofar as it determined that appellant's disability due to his December 18, 2000 employment injury ended by November 16, 2001. Insofar as this decision terminated appellant's entitlement to medical benefits for his accepted psychiatric condition, it is reversed.

Dated, Washington, DC
May 22, 2003

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member