

**United States Department of Labor  
Employees' Compensation Appeals Board**

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D.C., Appellant )

and )

U.S. POSTAL SERVICE, POST OFFICE, )  
Melville, NY, Employer )

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**Docket No. 09-31  
Issued: November 13, 2009**

*Appearances:*  
*Paul Kalker, Esq., for the appellant*  
*Office of Solicitor, for the Director*

*Case Submitted on the Record*

**DECISION AND ORDER**

Before:

ALEC J. KOROMILAS, Chief Judge  
DAVID S. GERSON, Judge  
MICHAEL E. GROOM, Alternate Judge

**JURISDICTION**

On October 3, 2008 appellant filed a timely appeal from a July 28, 2008 decision of the Office of Workers' Compensation Programs which terminated her compensation benefits. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the appeal.

**ISSUES**

The issues are: (1) whether the Office met its burden of proof to terminate appellant's compensation benefits on May 12, 2007; and (2) whether appellant has established continuing disability or residuals after that date.

On appeal, counsel contends that appellant sustained more extensive injuries than those accepted by the Office and that the reports of the referral physicians lacked probative medical rationale when compared to appellant's treating physician.

## **FACTUAL HISTORY**

On October 22, 2005 appellant, then a 45-year-old distribution operations supervisor, sustained injury to her back, neck, arms and head when she was struck by a bulk mail carrier being pushed by a coworker. She stopped work on the date of the injury. On December 19, 2005 the Office accepted appellant's claim for sprain/strains of the cervical and lumbosacral spine.

On December 29, 2005 Dr. Michael Soojian, a Board-certified internist, diagnosed lumbar sprain, left sacroiliitis and reversal of the cervical lordosis. He advised that appellant was disabled for work. A December 29, 2005 magnetic resonance imaging (MRI) scan of the lumbar spine revealed a 5.0 millimeter herniated disc at L5-S1 with the right side more involved. There were also bulging discs at L3-4 and L4-5 and degenerative disc disease from T12 to S1 with reactive changes at L4-5 and active degenerative disc disease at L5-S1. The lumbar spine showed mild scoliosis and Schmorl's nodes at several levels with hemangiomas within L4 and S1. On January 12, 2006 Dr. Soojian listed findings on examination and advised that appellant had limited cervical spine range of motion which was caused by the lumbar spine injury disrupting the central plumb line. He attributed the findings on MRI scan to appellant's accepted injury.

Dr. Soojian referred appellant to Dr. Luis M. Fandos, a Board-certified anesthesiologist with a subspecialty in pain medicine. He diagnosed lumbar sprain, reversal of the cervical lordosis and left sacroiliitis caused or aggravated by appellant's employment.

In a February 2, 2006 report, Dr. Fandos assessed appellant with herniated disc without myelopathy, lumbar, "MFPS/FMS" and facet arthropathy syndrome. He noted that appellant was in a great deal of pain and was limited in her activity level. Dr. Fandos recommended a series of selective nerve root block injections. Subsequent treatment notes from Dr. Soojian reiterated that appellant was totally disabled.

On April 21, 2006 Dr. Samir Haddad, an attending neurologist, noted that appellant experienced excruciating back pain since the October 23, 2005 work injury. He needed to rule out cervical radiculopathy, versus myelopathy and lumbar radiculopathy. Dr. Haddad also needed to rule out neuropathy to the lower extremities. He suggested an MRI scan of the spine. A May 30, 2006 MRI scan of the cervical spine revealed degenerative disc disease from C2 to T1, bulging discs with osteophytic spurs from C4-7 and narrowing of the neural foramina at C5-6 on both sides. There was no evidence of a herniated disc or intraspinal mass lesions.

On May 26, 2006 the Office referred appellant to Dr. Dwight Blum, a Board-certified orthopedic surgeon, for a second opinion. In a June 13, 2006 report, Dr. Blum reviewed the history of injury and medical treatment. He noted that appellant stood five feet, nine inches, weighed 200 pounds and complained of neck pain without radiation. Appellant also had low back pain without radiation since the lumbar blocks. Dr. Blum reviewed the diagnostic studies which showed degenerative disc disease and contrasted the MRI scan results of May 26, 2006, which revealed no cervical herniated disc, with the lumbar scan, which showed a herniated disc at L5-S1. Both studies revealed degenerative disc disease. Dr. Blum listed findings on range of motion, noting tenderness to palpation from L4-S1 with no spasm noted. The cervical spine

revealed tenderness in the trapezius and rhombus muscles bilaterally with no spasm noted. Dr. Blum diagnosed cervical and lumbosacral spondylosis with sprains and radiculopathy of the right lower extremity. He advised that appellant's present condition was an aggravation of her preexisting arthritis involving the cervical and lumbar spines. Dr. Blum noted that Dr. Fandos described some peripheral neuropathy, which he attributed to appellant's prior treatment for post breast cancer, possibly from her medication. He advised that appellant had not fully recovered from the October 22, 2005 injury but had the capacity to return to sedentary work with restrictions on bending, lifting and walking and work up from four hours a day to full time.

In a June 8, 2006 report, Dr. Soojian found right paravertebral muscle spasms with limited range of motion of the lumbar spine in all planes. Straight leg raising was positive at 50 degrees. On examination the cervical spine showed limited motion with pain and paresthesias to the right arm from the C6 nerve distribution. Dr. Soojian advised that appellant remained totally disabled. On October 3, 2006 he found muscle spasm with limitation of motion. In an October 17, 2006 note, Dr. Soojian reiterated that appellant remained disabled from work. On November 27, 2006 there were no major changes noted.

The Office found a conflict in medical opinion between Dr. Soojian, for appellant, and Dr. Blum, for the Office, as to appellant's continuing disability. It referred appellant to Dr. Allen Ray Haag, a Board-certified orthopedic surgeon, for an impartial medical examination.

In an October 30, 2006 report, Dr. Haag reviewed the history of injury and medical treatment. Examination of the neck revealed a full range of motion and the right shoulder slightly limited full abduction due to appellant's previous mastectomy. Otherwise, range of motion was full in both upper extremities. Dr. Haag reported a mild scoliosis of the lumbar area and negative straight leg raising. He diagnosed contusion and strain of the lumbosacral region and slight sprain of the cervical area. Dr. Haag reviewed the diagnostic studies of records. He noted that appellant was treated with physical therapy and pain management and found no evidence of a herniated disc to either the cervical or lumbar regions, with preexisting scoliosis of the lumbar spine. Dr. Haag advised that appellant had recovered from the accepted injury and could be working. In a work capacity evaluation, he noted that appellant was able to work eight hours a day with no restrictions.

On November 13, 2006 the Office requested clarification from Dr. Haag, specifically as to the December 29, 2005 MRI scan which revealed a central herniated disc to the lumbar spine at L5-S1. Dr. Haag was asked to further explain whether the accepted injury had aggravated appellant's preexisting degenerative disc disease. In a November 20, 2006 response, he stated:

"The inspection of the back showed no deformity. There was no pelvic tilt or list of the back. There was full flexion, extension, lateral bending and rotation of the spine. There was slight scoliosis in the lumbar region. No spasms noted. Flexion, lateral bending and rotation of the spine were normal in amount which can vary according to age and size.

"There is no herniated disc. Radiological report is not a clinical diagnosis based on pain, physical findings and radiological report. Clinical report of a herniated

disc is based on history, physical examination and radiological report, but they must all fit.

“Sometimes radiological report showed a herniated disc on the right, but the pain is on the left. Some people walk around with report of a herniated disc and have no pain at all, which proves there are [two] separate entities, clinical report of a herniated disc and a radiological report of a herniated disc.

“Currently [appellant] does not have any objective findings of any disease of her cervical or lumbar spines. Scoliosis when antedated an injury increases the likelihood of having pain subsequent to the injury she sustained, but not a permanent aggravation, but only temporarily.”

On December 21, 2006 the Office issued a notice of proposed termination of appellant’s compensation benefits based on the opinion of Dr. Haag.

On January 12, 2007 Dr. Haddad disagreed with the findings by Dr. Haag, stating that his determination that there was no evidence of disc herniation was “completely false.” He noted that the cervical spine MRI scan of May 26, 2006 demonstrated degenerative disc disease from C3 through T1, bulging discs with osteophytic spurs from C4 through C7 with narrowing of the neural foramina at C5-6 on both sides. Dr. Haddad noted that the December 29, 2005 MRI scan demonstrated a 5.0 mm central herniated disc at L5-S1 with the right side more involved. He also noted bulging discs at L3-4 and L4-5 as well as degenerative disc disease from T12 to S1 with reactive change at L4-5 and active degenerative disc disease at L5-S1. Dr. Haddad also noted nodes at several levels and hemangionas within L4 and S1. He advised that these were significant findings which greatly impacted appellant’s ability to recover from her injury. Dr. Haddad examined appellant on January 12, 2007 and found moderate tenderness in her cervical spine and trapezius bilaterally and diffuse tenderness associated with the musculature of the lumbosacral spine. He noted motor examination showed 4/5 in the muscles associated with the lumbar spine and lower extremities. Dr. Haddad also noted bilateral hamstrings and ilipsas length were short and that this was caused by muscular contracture spasms which inhibit complete muscle effectiveness. Although appellant made some improvement, she continued to experience diffuse findings from a neurological perspective. Dr. Haddad found that appellant remained disabled from work and had not reached maximum medical improvement.<sup>1</sup>

On January 18, 2007 Dr. Soojian disagreed with Dr. Haag, reiterating that appellant was totally disabled for work. He noted that appellant had been under care since November 17, 2005 for lumbosacral spine pain with paravertebral muscle spasms and right leg paresthesias. Appellant had documented positive findings on the December 29, 2005 MRI scan which showed a 5.0 mm central herniated disc at L5-S1 with right side more involved. Dr. Soojian also noted bulging discs at L3-4 and L4-5 with degenerative disc disease from T12 to S1 and mild lumbar

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<sup>1</sup> Appellant also submitted medical evidence from her chiropractor, Dr. James H. Lambert, who advised that appellant remained totally disabled as a result of the October 22, 2005 injury. A chiropractor is not a physician under the Federal Employees’ Compensation Act unless it is established that there is a subluxation as demonstrated by x-ray evidence. *See Mary A. Ceglia*, 55 ECAB 626 (2004). As Dr. Lambert did not diagnose a subluxation by x-ray, he is not a physician as defined and his report is of no probative value. *Isabelle Mitchell*, 55 ECAB 623 (2004).

spine scoliosis. Diagnostic testing of October 22, 2005 revealed evidence of radiculopathy, bilaterally. Despite continuing treatment, appellant remained symptomatic and required further pain management, physical therapy and orthopedic follow up.

On February 15, 2007 Dr. Fandos reiterated his diagnoses of appellant's lumbar and cervical conditions and summarized his medical treatment. He noted that she had good response to the lumbar facet joint injections, but noted that her symptoms were starting to recur. Given the chronicity of her symptoms and partial response to treatment, appellant would probably not be able to carry on with normal eight-hour-a-day activity. In a work capacity evaluation of February 28, 2007, Dr. Fandos placed limits on appellant's sitting, walking, standing one to four hours and prohibited reaching and bending and stooping.

By decision dated May 20, 2007, the Office terminated appellant's compensation benefits. It found the weight of medical opinion represented by Dr. Haag.

By letter dated April 28, 2008, appellant, through her attorney, requested reconsideration. In a January 29, 2008 report, Dr. Haddad reiterated his treatment of appellant and listed his medical diagnoses as: lumbar herniated nucleus pulposus, lumbar radiculopathy, lumbar muscle spasm, lumbar muscular atrophy due to nerve degeneration, lumbar decreased range of motion, cervical bulging discs, cervical radiculopathy, cervical muscular spasm, cervical muscular atrophy and cervical decreased range of motion. He advised that all of the clinical findings and associated diagnoses were directly related to appellant's work accident. Dr. Haddad reiterated his disagreement with the opinions of Dr. Blum and Dr. Haag.

By decision dated July 28, 2008, the Office denied modification of the May 10, 2007 decision.

### **LEGAL PRECEDENT**

Once the Office has accepted a claim, it has the burden of justifying termination or modification of compensation benefits.<sup>2</sup> It may not terminate compensation without establishing that disability ceased or that it was no longer related to the employment.<sup>3</sup> To terminate authorization for medical treatment, the Office must establish that an employee no longer has residuals of an employment-related condition, which require further medical treatment.<sup>4</sup> Its burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.<sup>5</sup>

The Act provides that if there is a disagreement between the physician making the examination for the United States and the physician of the employee the Secretary of Labor shall

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<sup>2</sup> *I.J.*, 59 ECAB \_\_ (Docket No. 07-2362, issued March 11, 2008); *Fermin G. Olascoaga*, 13 ECAB 102, 104 (1961).

<sup>3</sup> *J.M.*, 58 ECAB \_\_ (Docket No. 06-661, issued April 25, 2007); *Anna M. Blaine*, 26 ECAB 351 (1975).

<sup>4</sup> *T.P.*, 58 ECAB \_\_ (Docket No. 07-60, issued May 10, 2007); *Furman G. Peake*, 41 ECAB 361, 364 (1990).

<sup>5</sup> 5 U.S.C. §§ 8101-8193, 8123.

appoint a third physician who shall make an examination.<sup>6</sup> The implementing regulations states that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an Office medical adviser or consultant, the Office shall appoint a third physician to make an examination. This is called a referee examination and the Office will select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case.<sup>7</sup> The opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.<sup>8</sup>

### ANALYSIS

The Office accepted that appellant sustained injury on October 22, 2005, accepted for sprain/strains of the cervical and lumbosacral spine. The record reveals that she was treated by Drs. Soojian, Fandos and Haddad. Dr. Soojian found that she had a lumbar sprain, left sacroiliitis and reversal of cervical lordosis and that these conditions were causally related to her employment injury and rendered her disabled from work. He reviewed appellant's December 29, 2005 MRI scan and noted that it was positive for herniated disc at L5-S1 with right side more involved and bulging discs. Dr. Soojian also attributed her degenerative disc disease of the cervical and lumbar spines, in part, to the accepted injury. Dr. Fandos treated appellant's pain with a series of selective nerve root blocks. He too found that appellant had a herniated disc with persistent paraspinal spasm at L4-5 and diagnosed bilateral lumbar radiculopathy which he attributed to the employment injury.

The Office referred appellant to Dr. Blum for a second opinion. Dr. Blum diagnosed cervical and lumbosacral spondylosis and with sprain and radiculopathy on the right lower extremity. He did not find that appellant had fully recovered from the October 22, 2005 injury or had reached maximum medical improvement. Dr. Blum opined that the injury had caused an aggravation of her degenerative disc disease. He found, however, that appellant had the capacity to return to sedentary work, working up to full time, within specified physical restrictions.<sup>9</sup>

Finding a conflict between Dr. Soojian and Dr. Blum, the Office referred appellant to Dr. Haag for an impartial medical examination. It listed the source of the conflict as appellant's diagnosis and whether there was continuing disability due to the accepted injury. The Board finds that there was no conflict between Dr. Soojian and Dr. Blum as to whether appellant had residuals from her work injury; both physicians concluded that there were residuals and that she had not reached maximum medical improvement. Dr. Haag, however, advised that appellant needed no further medical treatment with regard to her accepted injury. He noted that appellant had no current objective findings of any disease in her cervical or lumbar spines. Dr. Haag's

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<sup>6</sup> 20 C.F.R. § 10.321.

<sup>7</sup> See *J.J.*, 60 ECAB \_\_\_ (Docket No. 09-27, issued February 10, 2009).

<sup>8</sup> See *LaDonna M. Andrews*, 55 ECAB 301 (2004).

<sup>9</sup> Counsel contended that if the Office had properly developed the medical evidence, there would be no need for a second opinion. The Board notes that the Office determines the necessity for a second opinion examination. See 20 C.F.R. § 10.320. It is not for the claimant to decide whether circumstances lend themselves to a second opinion. See *E.B.*, 59 ECAB \_\_\_ (Docket No. 07-1618, issued January 8, 2008).

opinion as to whether appellant had any continuing medical condition as a result of her accepted work-related injury is not entitled to the special weight normally given an impartial medical examiner as he was not resolving a conflict as to whether she had any residuals from her accepted injury. His opinion with regard to whether appellant had residuals may only be considered as a second opinion physician.

The Board also notes that Dr. Haag's opinion is not entitled to weight with regard to whether appellant remains disabled. The Board finds that Dr. Haag's opinion is not well rationalized. On October 30, 2006 he conducted a physical examination of appellant and reviewed her medical records. Dr. Haag listed the December 29, 2005 MRI scan which found a central herniated disc at L5-S1. However, he stated, "There was no evidence of a herniated disc, clinically or even by MRI scan of the cervical and lumbar area." When asked to clarify his opinion, Dr. Haag reiterated that there was no herniated disc, and explained that a radiological report is not a clinical diagnosis based on pain, physical findings and radiological report. He stated, "Clinical report of a herniated disc is based on history, physical examination and radiological report, but they must all fit." This statement is not well explained. Moreover, Dr. Haag did not specifically address the accepted cervical and lumbar sprains or respond to the Office's inquiry regarding whether appellant's degenerative disc disease or bulging discs had been aggravated by her injury.

As noted, the conditions accepted by the Office in this case were sprain/strains of the cervical and lumbar spine. On appeal, counsel for appellant contends that she sustained more extensive injuries to her cervical and lumbosacral regions, including the herniated lumbar disc and degenerative disc disease. For the conditions not accepted by the Office she bears the burden of proof. The December 29, 2005 MRI scan showed a herniated L5-S1 disc with degenerative disc disease of the spine. The cervical MRI scan did not reveal a herniated disc, but found degenerative disc disease. Dr. Soojian discussed the positive MRI scans and related his continuing treatment of appellant to the October 22, 2005 injury for residuals of this incident. Dr. Haddad noted that the lumbar MRI scan showed a herniated disc in addition to bulging discs at multiple levels and degenerative disc disease. Dr. Blum, the referral physician, addressed the diagnostic studies and advised that her condition constituted an aggravation of her preexisting degenerative disease. Only Dr. Haag, without sufficient rationale, stated that there was no evidence of a herniated disc. His opinion does not effectively rebut the extensive evidence to the contrary.

### **CONCLUSION**

The Board finds that the Office failed to meet its burden of proof to terminate appellant's compensation benefits as of May 12, 2007.<sup>10</sup>

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<sup>10</sup> In light of this disposition of the first issue, the second issue is moot.

**ORDER**

**IT IS HEREBY ORDERED THAT** the July 28, 2008 decision of the Office of Workers' Compensation Programs be reversed.

Issued: November 13, 2009  
Washington, DC

Alec J. Koromilas, Chief Judge  
Employees' Compensation Appeals Board

David S. Gerson, Judge  
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge  
Employees' Compensation Appeals Board