U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of MARILYN Y. COX and DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Milwaukee, Wis.

Docket No. 98-1190; Submitted on the Record;
Issued August 10, 1998

DECISION and ORDER

Before MICHAEL J. WALSH, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether the Office of Workers' Compensation Programs properly terminated appellant's compensation effective September 15, 1996.

On October 28, 1992 appellant, then a 31-year-old food service worker, was getting dishes for the next meal when a cart pushed by a coworker struck her in the right knee and leg. She stopped work on October 29, 1992 and returned to work on November 23, 1992. Appellant stopped work again on December 29 through December 30, 1992. She received continuation of pay for these dates. The Office accepted appellant's claim for contusion of the right knee, post-traumatic prepatella bursitis, and bulging L4-L5 and L5-S1 bulging discs. She received temporary total disability compensation for the periods February 23 through May 21, 1993 and after September 10, 1993. In an August 20, 1996 decision, the Office terminated appellant's compensation effective September 15, 1996 on the grounds that any disability related to the October 28, 1992 employment injury had ceased. In a March 14, 1997 merit decision, the Office denied appellant's request for modification of the August 20, 1996 decision.

The Board finds that the Office properly terminated 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]

In an October 29, 1992 note, Dr. James W. Hare, a Board-certified family practitioner, diagnosed post-traumatic, prepatellar bursitis. In a November 16, 1992 report, Dr. Domenic J. Pulito, an orthopedic surgeon, indicated that appellant complained of pain in the right knee. He

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

noted that appellant had mild inflammation of the patellar tendon. Dr. Pulito reported that appellant had a full range of motion of the knee. He commented that appellant's symptoms were somewhat disproportionate to the physical findings. In a November 24, 1992 report, Dr. Pulito indicated that appellant's findings were essentially normal. In a March 23, 1993 report, Dr. Pulito related that appellant had been complaining of leg pain. He opined that appellant did not have a radiculopathy but more stocking glove-type paresthesias. In an April 20, 1993 report, he indicated that a magnetic resonance imaging (MRI) scan of the right knee was negative.

In a June 17, 1993 report, Dr. Charles Supapodok, a neurologist, stated that an electromyogram (EMG) and nerve conduction studies of appellant's legs were negative. He diagnosed probable contusion of the right knee and probable musculoligamentous strain of the lumbosacral paraspinal muscles. In a series of reports Dr. James Lloyd, a Board-certified neurosurgeon, restricted appellant to working four hours a day. However, he did not provide a diagnosis of appellant's condition. In a March 31, 1994 report, Dr. Thomas J. Ryan, an anesthesiologist, stated that an MRI of the back showed bulging discs at L4-L5 and L5-S1.

In a January 10, 1995 report, Dr. Robert Goldman, a Board-certified neurologist of professorial rank who was requested by the Office to give a second opinion, commented that appellant had a long history of recurrent back pain following what appeared to be a minor accident. He related that the examination was significant for appellant's depression with the absence of specific focal neurological findings. Dr. Goldman indicated that appellant showed significant weakness in leg movements associated with significant pain. He reported that sensation was intact to pin and light touch. Dr. Goldman stated that he would refer appellant for an EMG in the unlikely event that she had radiculopathy. In a January 13, 1995 report, Dr. Paul Barkhaus, a Board-certified neurologist, stated that appellant had no abnormalities on the EMG. He concluded there was no electronic evidence for a left L2-S1 radiculopathy.

The Office referred appellant, together with the statement of accepted facts and the case record, to Dr. Robert W. McCabe, a Board-certified orthopedic surgeon, for an examination and another second opinion. In a February 15, 1995 report, Dr. McCabe commented that appellant exhibited extreme pain behavior. He stated that examination of the lumbar spine was inconclusive because of extreme exaggeration. Dr. McCabe noted that appellant held herself that 15 degrees of flexion and would not bend further forward, posteriorly or laterally. He reported remarkable tenderness over the lower lumbar vertebrae. Dr. McCabe indicated that straight leg raising was limited and he could not raise appellant's leg more than three inches off the mat because of resistance. He found no visible atrophy although he noted that appellant had an apparent slight increase in circumference of the right leg above and below the knee of symmetrical which suggested congenital asymmetry. Dr. McCabe reported appellant had no muscular weakness although testing of appellant required repeated attempts. He found a sensory deficit on the dorsum of the right foot extending to and above the knee which was inconclusive. Dr. McCabe stated that examination of the right knee showed no effusion, a complete range of motion, no joint instability, no pain on compression of the patella and no patellofemoral grating. He concluded that the knee examination was within normal limits. Dr. McCabe reported that x-rays of the lumbar spine was normal with no degenerative changes, no congenital abnormalities and no concurrent evidence of disease. He concluded that appellant had complaints of lower back and right leg pain and numbness but stated that no disease was found. Dr. McCabe

indicated that he was awaiting results of an MRI scan. In a March 15, 1995 note, Dr. McCabe stated he had reviewed the January 31, 1994 MRI scan and stated that he saw no evidence of any abnormal findings. He commented that the bulging described by the radiologist was a normal variant. Dr. McCabe indicated that when the subjective complaints and the objective findings were considered in relating to the MRI scan, the scan was negative. He concluded that he was unable to substantiate that appellant was disabled. Dr. McCabe commented that this was not to say that nothing happened on October 28, 1992, only that appellant had possibly a temporary injury involving the spinal mechanism. He stated that the current evidence showed appellant had recovered completely as he could find no residuals of an injury to explain her virtual total disability. Dr. McCabe noted that he looked for an intraspinal cause for appellant's pain but no preexisting conditions such as arthritis, infection, tumor or congenital anomaly was found. He stated that, on the basis of the MRI scan, that any hidden or unknown condition would appear in the future. Dr. McCabe did not recommend any restrictions for appellant and indicated that she did not represent any risk for an employer with the qualification that if she had severe back pain as she maintained, she should look for a job with little stress on her back. He stated that any restrictions should not be interpreted to be the result of an injury at work.

A review of the medical evidence shows that, while appellant complained of severe back and leg pain, the complaints were not supported by the findings of the physicians who examined her. Dr. Hare diagnosed bursitis but did not describe how he reached that diagnosis and did not state how he related the condition to appellant's employment injury. Dr. Pulito indicated that his examination of appellant's right knee was normal and reported that an MRI scan of the right knee was negative. Dr. Supapodok and Dr. Goldman stated that EMG studies of appellant's leg were within normal limits. Dr. McCabe reviewed appellant's lumbar MRI scan and found that any bulging reported was within normal limits. He concluded, based on his own examination, that appellant had fully recovered from any injury sustained on October 28, 1992. The weight of the medical evidence therefore established that appellant no longer had any disability causally related to the employment injury. The Office had sufficient medical evidence to support its decision to terminate appellant's compensation.

Appellant submitted a January 17, 1997 report from Dr. Sherwin Goldman, a Board-certified orthopedic surgeon, who stated that the examination was difficult and indicated that appellant had an extreme amount of pain and a multiplicity of Waddell's nonorganic findings for a score of 5/5. He commented that all modalities were difficult to check and that if there was a true organic cause to appellant's condition it would be very hard to elicit. Dr. Goldman reported that an x-ray of the right knee was normal. X-rays of the cervical and lumbar regions showed mild hypertrophic changes. A January 15, 1997 MRI scan of the cervical and lumbar regions showed mild degenerative changes in both regions with no disc problems and a normal spinal cord. Dr. Goldman stated that an EMG of the right arm and right leg was normal. He diagnosed chronic mechanical neck and low back pain and chronic pain disorder. Dr. Goldman's report did not address whether appellant had any condition causally related to the employment injury. Many of the tests he performed yielded normal results. Dr. Goldman noted that appellant's examination was so difficult that he would be unable to tell if she had an organic cause for her

condition. His report therefore is insufficient to rebut the evidence of record showing that appellant's employment-related condition has ceased.[2]

The decision of the Office of Workers' Compensation Programs, dated March 14, 1997, is hereby affirmed.

Dated, Washington, D.C.
August 10, 1998

Michael J. Walsh
Chairman

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member

[2] On appeal, appellant noted that the Social Security Administration determined that she was totally disabled. The Board notes that the finding under the Social Security Act is not dispositive of appellant's claim under the Federal Employees' Compensation Act. The Social Security Act and the Federal Employees' Compensation Act have different standards of medical proof on the question of disability; *see Daniel Deparini*, 44 ECAB 657 (1993).