U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of PATRICIA A. FAST <u>and</u> U.S. POSTAL SERVICE,
POST OFFICE, Redlands, Calif.

Docket No. 97-497; Submitted on the Record;
Issued February 18, 1999

DECISION and ORDER

Before MICHAEL J. WALSH, GEORGE E. RIVERS,
MICHAEL E. GROOM

The issue is whether the Office of Workers' Compensation Programs met its burden to terminate appellant's compensation and medical benefits.

On September 23, 1991 appellant, then a 42-year-old letter carrier, filed a notice of traumatic injury, alleging that she injured her lower back on September 20, 1991 when she rearranged and loaded flat trays in a vehicle in the course of her federal employment. On November 13, 1991 the Office accepted the claim for lumbar strain and appellant received appropriate compensation. Appellant subsequently accepted a limited-duty position.

On January 13, 1994 Dr. James E. Shook, appellant's treating physician and a Board-certified orthopedic surgeon, diagnosed chronic discogenic disease in the lumbar spine, multilevel and chronic musculoligamentous strain, lumbar spine. He stated that appellant had a partial disability allowing her to work six hours per day.

On February 7, 1994 Dr. Shook stated that appellant could intermittently sit for 6 hours per day, intermittently walk for 4 hours per day and intermittently lift 0 to 10 pounds for 4 hours per day. He indicated that appellant could bend for one hour per day and that she could squat for four hours per day. Dr. Shook stated that appellant could not climb or kneel. He stated that appellant could twist for one hour per day and stand for four hours per day. Dr. Shook set a lifting restrictions of 10 to 20 pounds. He checked "yes" to indicate that appellant could work eight hours per day.

On April 8, 1994 Dr. Shook indicated that appellant could intermittently lift 10 pounds for 6 hours per day and that appellant could continuously sit for 6 hours per day. He stated that appellant could stand and walk for no more than one hour at a time for six hours per day. Dr. Shook indicated that appellant could not climb, but that on an intermittent basis appellant could kneel, bend/stoop and twist, each for one hour per day. He stated that appellant could not push/pull or reach above her shoulder. Finally, Dr. Shook stated that appellant could not drive

more than two hours per day. He checked "yes" to indicate that present condition was due to the injury for which compensation was claimed.

On April 14, 1994 Dr. Shook indicated that appellant could only work six hours per day within the previously described work restrictions.

On May 5, 1994 Dr. Shook indicated that appellant could continue to work without restrictions. However, on June 2, 1994 he stated that appellant can work as she has been with the previously stated work restrictions.

On July 18, 1994 Dr. Shook indicated that appellant could return to work eight hours per day with restrictions.

On August 2, 1994 the Office referred appellant, along with a statement of accepted facts, to Dr. Ian D. Brodie, a Board-certified orthopedic surgeon, for a second opinion examination.

On August 18, 1994 Dr. Shook indicated that appellant could continue to work her modified duties with a 20-pound limit on lifting and a 6-hour workday. He stated that appellant's industrial injury started as a musculoligamentous strain to her lumbar spine, but with time her symptoms have been chronic and persistent. Dr. Shook stated that it appeared her traumatic lesion to her lumbar spine led into post-traumatic disc disease. He stated that even without the injury of September 20, 1991, appellant would have experienced similar symptoms within five years due to degenerative disc disease. Dr. Shook further stated that appellant could lift only 20 pounds and that she could work only a limited hour workday.

On August 31, 1994 Dr. Brodie provided his second opinion examination. He reviewed appellant's history and x-rays, and conducted a physical examination. Dr. Brodie diagnosed chronic soft tissue strain of the neck and low back, continued symptoms due to healing of scar tissue which forms adhesions which, on occasion, stretch and tear accounting for flare-ups of pain, intermittent stiffness and spasming of irritated muscles when a flare-up occurs. He stated that appellant did not have degenerative disc disease of the cervical or lumbar spine by either x-ray or magnetic resonance imaging (MRI). Dr. Brodie stated that appellant should be limited to lifting 30 pounds or more repetitively and that she could work a full 8 hour day with that restriction.

On September 29, 1994 Dr. Shook diagnosed post-traumatic disease of the lumbar spine and stated appellant could work a 6-hour day with a ten-pound limit on lifting. He repeated this assessment on November 3, 1994.

On December 6, 1994 Dr. Shook stated that an injury to appellant's neck in 1990 and her low back in 1991 resulted in musculoligamentous strain to the cervical and lumbar spine with superimposed disc injury in the mid-cervical and lower lumbar spine. He stated that these injuries have progressed and that now there is evidence of post-traumatic stress disc disease with changes such as osteophyte formation and disc dehydration. Dr. Shook stated that appellant could only work six hours per day without exacerbating her symptoms. He stated that appellant was unable to return to her usual employment and unable to work an eight-hour day. Dr. Shook stated that appellant could work a six-hour day with approximately three hours sitting and three

hours standing. He stated that she could not perform repetitive bending, stooping or lifting. Dr. Shook stated that she could only lift from the waist to the shoulder level with a limit of 20 pounds. He stated that he disagreed with Dr. Brodie's conclusion that appellant did not have degenerative disc disease based on his reading of the x-rays and magnetic resonance imagings. Dr. Shook stated that appellant sustained post-traumatic stress disease in her cervical and lumbar spine, as well as musculoligamentous strain.

On December 15, 1994 Dr. Shook repeated his diagnosis, but stated that appellant could work an eight-hour day if her commute was counted in that time. He still limited appellant to lifting 10 pounds.

The Office found that a conflict existed between the opinion of Dr. Shook, appellant's treating physician, diagnosing degenerative disc disease and stating that appellant could not work more than six hours per day and the opinion of Dr. Brodie, diagnosing no evidence of degenerative disc disease and stating that appellant could work eight hours a day with restrictions. It, therefore, referred appellant to Dr. Ronald D. Levin, a Board-certified orthopedic surgeon, for an impartial examination on January 12, 1995.

On February 7, 1995 Dr. Levin rendered his impartial opinion. He reviewed the medical records and appellant's history of injury. Dr. Levin noted that appellant complained of intermittent discomfort in her lower back which was dull and burning. He recorded that the pain worsened when appellant picked up heavy items or bent over for too long. Dr. Levin also noted back stiffness. He noted that appellant's usual employment involved lifting up to 70 pounds and performing frequent pushing, pulling, carrying, bending, squatting, kneeling, twisting, standing, sitting, driving, climbing, overhead reaching and repetitive hand movements. He conducted a complete physical examination. Dr. Levin stated that he believed appellant had normal lumbar flexion. He reviewed appellant MRIs and found them to be essentially negative. Dr. Levin diagnosed lumbar strain with no evidence of significant disc protrusion. He stated that appellant had a soft tissue injury, but that she has no significant disability. Dr. Levin indicated that appellant's symptoms were subjective as there was no objective evidence supporting any significant disease. He stated that appellant did not have a significant degenerative disc disease. Dr. Levin found no need for continued medical treatment and stated that the only limitation on appellant was that she should not lift over 75 pounds. He, therefore, found that appellant was capable of performing her usual employment for eight hours per day.

On April 6, 1995 Dr. Shook indicated that appellant could work 8 hours per day including driving time, but that appellant could not push, pull or lift over 10 pounds.

On April 13, 1995 the Office issued a "Notice of Proposed Termination of Compensation" on the basis that appellant ceased to have work restriction or need for medical treatment causally related to her work injuries. The Office indicated that it relied on the opinion of Dr. Levin, the impartial specialist, in reaching its decision. Appellant was given 30 days to submit additional evidence or argument.

By decision dated May 15, 1995, the Office ordered that the claim for compensation be rejected because the weight of the medical evidence established that claimant had no work

restrictions or need for medical treatment causally related to the work injury she sustained on September 20, 1991.

Following the Office's decision, it received an April 27, 1995 report from Dr. Shook indicating that he never opined that appellant was able to work without restrictions. He stated that she could only work six hours per day. Dr. Shook further stated that appellant had a restricted lumbar range of motion, contrary to Dr. Levin's finding. He again diagnosed post-traumatic discogenic disease based on appellant's history, complaints and clinical course. Dr. Shook also provided his Office notes from this visit. In a letter dated May 17, 1995, the Office indicated that this report failed to change the weight of the evidence.

On May 19, 1995 appellant requested an oral hearing.

On June 5, 1995 Dr. Shook again diagnosed post-traumatic disc disease of the lumbar and cervical spine with pain. He stated that appellant could work 6 hours per day lifting less than 10 pounds.

On May 10, 1996 Dr. Shook repeated his diagnoses and his assessment of appellant's work restrictions, but added that appellant should limit fine manipulation, keyboarding, to one hour per day.

On May 31, 1996 Dr. Shook stated that appellant could answer telephones, reserve poll vehicles, take vehicles in for servicing, schedule maintenance updates, prepare forms, shuttle vehicles, pick up parts, time-keeping backup and receive parts eight hours per day. He stated that she could input and process work orders and file work orders, three hours per day, a half an hour per time. Dr. Shook stated that there was a 20-pound limit on lifting.

A hearing was held on September 11, 1996.

By decision dated October 17, 1996, the Office hearing representative affirmed the Office's May 15, 1995 decision terminating benefits. The Office found that the opinion of Dr. Levin, the impartial examiner, stating that appellant could perform her usual employment and that she no longer needed medical treatment constituted the weight of the medical evidence.

The Board finds that the Office met its burden of proof to terminate appellant's compensation and medical benefits.

Once the Office has accepted a claim and pays compensation, it has the burden or proof 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] Furthermore, the right to medical benefits for the accepted condition is not limited to the period of entitlement to disability.[2] To terminate authorization for medical

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

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

treatment, the Office must establish that appellant no longer has residuals of an employment-related condition which no longer requires further medical treatment.[3]

In the present case, the Office accepted appellant's claim for a lumbar sprain and authorized appropriate compensation benefits. Subsequently, appellant's treating physician, Dr. Shook examined appellant and diagnosed degenerative disc disease that allowed appellant to work only six hours per day. Dr. Brodie however, found that there was no evidence of degenerative disc disease and that appellant could work eight hours per day. Because of the conflict between these two reports, the Office eventually referred appellant to Dr. Levin for an impartial medical examination pursuant to section 8123 of the Act.[4]

In situations where there are opposing medical reports of virtually equal weight and the case is referred to an impartial specialist, the opinion of such a specialist will be given special weight if the opinion is based on proper factual background and well rationalized.[5] Dr. Levin opined that there were no residuals resulting from the September 20, 1991 accepted injury. He reviewed appellant's entire history and performed a complete physical examination. Dr. Levin also reviewed magnetic resonance imaging scans and x-rays and based on these objective findings he indicated that there was no significant evidence of degenerative disc disease or any residuals resulting from the 1991 injury. Because Dr. Levin's opinion was based on a proper factual background and medical rationale, his opinion, as the opinion of the impartial medical specialist, constitutes the weight of the evidence. The Board, therefore, finds that the Office met its burden to terminate appellant's compensation benefits. Moreover, the subsequently submitted reports from Dr. Shook failed to outweigh Dr. Levin's opinion inasmuch as these reports were cumulative of the evidence he previously submitted prior to the impartial examination.

[3] *Id.*

[4] 5 U.S.C. § 8128 *et seq.*

[5] *See Jack R. Smith*, 41 ECAB 691 (1990).

Accordingly, the decision of the Office of Workers' Compensation Programs dated October 17, 1996 is affirmed.

Dated, Washington, D.C.
February 18, 1999

Michael J. Walsh
Chairman

George E. Rivers
Member

Michael E. Groom
Alternate Member