U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of REGINALD CARTER and DEPARTMENT OF JUSTICE,
U.S. MARSHALS SERVICE, Los Angeles, CA

Docket No. 99-634; Submitted on the Record;
Issued June 7, 2000

DECISION and ORDER

Before GEORGE E. RIVERS, MICHAEL E. GROOM,
BRADLEY T. KNOTT

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

On December 21, 1995 appellant, then a 56-year-old criminal investigator, filed a notice of traumatic injury and claim for compensation alleging that on December 13, 1995 he sustained a lower back trauma when he leaned across the desk to sign some documents and felt intense pain in his back.

In support of his claim, appellant submitted a witness statement wherein G.D. Williams, a supervisor, verified appellant's statement as to how the event occurred. He indicated that appellant's symptoms were pale and clammy skin, heavy sweating, thick slurred speech, dropping of the jowl on left side, atoxia when he attempted to move and slight vertical nystagmus. Mr. Williams further indicated that appellant could not move more than a few steps without help. The witness stated that he called 911 because he was concerned that appellant had suffered a possible stroke.

Appellant submitted medical reports from Dr. John E. Lusche, a Board-certified orthopedic surgeon, dated December 15 and December 20, 1995, which indicated that appellant should remain off work until at least December 27, 1995. Dr. Lusche's medical progress notes were sent shortly thereafter.

In a medical report dated January 2, 1996, Dr. Thomas Ackerson, II, a Board-certified orthopedic surgeon, noted that appellant noticed abrupt onset of severe pain with radiation down his left upper extremity and noted that his initial impression was "probable neurologic inflammation left upper extremity." In his medical report dated January 24, 1996, Dr. Ackerson noted that he still believed that appellant's pain in his left upper extremity was neurologic in origin and may be an "ulnar neuropathy or a diabetic presentation." He further noted that there was "marked pain and tenderness and Tinel's sign at the left elbow, which has become quite

localized at this time." Dr. Ackerson concluded that appellant could not work "at this time." In a report dated February 23, 1996, he noted that appellant was "still having moderate difficulty with his left upper extremity with numbness, tingling and paresthesias.

On April 15, 1996 the Office accepted appellant's claim for a low back strain only.

In a decision issued May 13, 1996 and finalized on May 14, 1996, the Office found that the December 13, 1995 injury did not result in any injury to appellant's left arm, neck and upper back.

Appellant requested reconsideration by letter dated September 4, 1996.

In support of his request, appellant submitted another statement from Mr. Williams, who added to his original description of the events by stating:

> "I saw [appellant] lean across a desk to pick up a piece of paper, then he grabbed his back and started to fall to his knees, as he went down his elbow struck the desk, then Mr. Patrick F. Dailey and myself grabbed [appellant's] arms and prevented him from falling to the floor.
>
> "[Appellant] complained of pain in his back and arm."

Another witness, Mr. Dailey, stated that he would also testify that he saw appellant lean toward a desk to pick up a piece of paper and that appellant "grabbed his back and started to fall to the floor striking his elbow on the desk."

Appellant also submitted an August 20, 1996 report from Dr. Ackerson, wherein he noted that, although it was his initial impression that the individual had suffered an industrial injury with trauma in his left upper extremity and possibly his neck, that the "pain over the ensuing months gradually seemed to localize about the left elbow and indeed it seemed that the pain was emanating from the elbow region in the cubital tunnel." He continued:

> "Over the ensuing months, the individual has seemed to make modest improvement but still has numbness and tingling and winces with pain when the Tinel's sign is elicited at his elbow. He also has some loss of strength of his left upper extremity, primarily in the ulnar nerve distribution."

Dr. Ackerson believed that hospitalization and surgery for ulnar nerve transposition and cubital tunnel release would be necessary. He further stated:

> "In lengthy discussions with [appellant], I do feel that this is work related. He only has the desire to return to his prior injury level of performance and work."

Appellant also submitted a report of an electromyogram (EMG) conducted on May 1, 1996 by Dr. Vincent M. Fortanasce, a Board-certified neurologist, at the recommendation of Dr. Ackerson. This EMG indicated "definite evidence of C8-T1 radiculopathy, in addition the patient appears to have a moderate cubital tunnel syndrome and mild to moderate carpal tunnel syndrome."

Appellant also submitted his emergency room records from his December 13, 1995 admission to White Memorial Medical Center.

By decision dated October 9, 1996, the Office accepted that the condition of left cubital tunnel syndrome was also related to the injury of December 13, 1995.

After this decision, appellant continued to submit medical reports. Appellant submitted continuing reports from Dr. Ackerson dated from December 27, 1996 through September 8, 1997, wherein Dr. Ackerson indicated improving but continuing pain in the back and left elbow and recommended that appellant continue limited-duty work. Appellant also submitted a February 7, 1997 report of a magnetic resonance imaging (MRI) by Dr. David H. Schultz, a Board-certified radiologist, who concluded that there was five percent dextroscoliosis centered at L3 in the coronal plane, no medullary bone lesions or bony malalignments in the sagital plane, normal consus and paraspinal soft tissues, mild degenerative changes of the facet joints at L4-5 and L5-S1 and mild degenerative disc disease present at L3-4 and L5-S1. He concluded: "There are no disc protrusions, central spinal canal or foraminal stenosis or presence of any other intra or extradural lesions compromising the lumbosacral region of the spinal canal that might explain a right or left lower extremity radiculopathy." Appellant also submitted a report of an EMG dated June 18, 1997 by Dr. Fortanasce, which indicated:

> "Compared with previous study of May 17, 1996 ... the left cubital tunnel syndrome still remains, though slightly improved. The left carpal tunnel syndrome is definitely improved. Also, now there is no evidence of any denervation in the C8-T1 region."

On July 25, 1997 the Office referred appellant to Dr. Frederick D. Lieb, a Board-certified orthopedic surgeon, for a second opinion.

In a medical report dated August 12, 1997, Dr. Lieb, after conducting a physical examination and reviewing appellant's medical record, stated that appellant had low back strain resolved and cubital tunnel syndrome in his left elbow. He also found that appellant suffered from cervical spondylosis, moderately advanced, C3-7, preexisting and nonwork related. Dr. Lieb noted that from his review of the records, he questioned whether any work-related injury occurred, but that if he did sustain a work-related injury, it would have been a soft tissue stretching injury from which he is fully recovered without any permanent residuals. He further stated that the question of appellant's injury to his left elbow on December 13, 1995 "also was a bit of an enigma." Dr. Leib noted that appellant did not report an elbow injury during his December 1, 1995 visit to the emergency room. He further noted that although appellant did have findings of "cubital tunnel syndrome, *i.e.*, compression neuropathy of the ulnar nerve at the elbow, but he also has findings consistent with cervical radiculopathy involving the very same nerve roots, or at least an overlap thereof." The only finding on physical examination indicative of cubital tunnel syndrome is numbness of the left little finger. The decrease in sensation of the lateral brachium, the entirety of the left forearm and the entirety of the left right finger is not consistent with an ulnar nerve lesion. Furthermore, he demonstrated a negative Tinel's sign of the cubital tunnel, which is probably the most important physical finding characteristic of cubital tunnel syndrome. The EMG performed on May 17, 1996 revealed evidence of cubital tunnel

syndrome but also evidence which make me believe that cervical radiculopathy is more likely the cause of his symptoms than cubital tunnel syndrome.

Dr. Lieb stated that as a result of the December 13, 1995 incident referable to the lower back, appellant sustained, at the most, some soft tissue stretching injuries, for which he has had more than an adequate period of time for full recovery. He opined that these type of soft tissue injuries will generally heal over the course of a three- to eight-week period of time without medical care and that even with preexisting degenerative disc disease, maximal healing for these types of soft tissue injuries should occur within a three month time frame. Accordingly, Dr. Lieb opined that appellant's degenerative disc disease of the lumbosacral spine was the result of the natural degenerative process and was not related to work activities. He further opined that any injury, which occurred as a result of the December 13, 1995 incident has resolved without permanent residuals and that appellant was physically capable of returning to full duty.

On August 25, 1997 Dr. Lieb responded to questions from the Office by indicating that appellant should limit prolonged upward gaze, repetitive flexion/extension and rotation of the neck, but stated that appellant could perform repetitive motions of the wrist and elbow. Dr. Lieb further noted that none of the restrictions were due to the employment injury, but rather, that all of the above limitations are due to his preexisting advanced cervical spondylosis (degenerative changes).

On October 3, 1997 the Office issued its notice of proposed termination of compensation finding that the weight of medical evidence established he no longer suffered residuals the December 13, 1995 work-related injury.

Appellant sent the Office an October 16, 1997 report from Dr. Ackerson, which was received by the Office on October 27, 1997, wherein he noted that he disagreed with Dr. Lieb. Dr. Ackerson found that appellant was "still very symptomatic with reference to his left elbow and merely stroking or tapping the elbow causes marked pain and positive Tinel's sign. I still feel the individual needs surgery on his elbow...."

On November 19, 1997 the Office terminated appellant's compensation benefits, noting that appellant had not submitted any new medical evidence to counter the proposed termination of compensation benefits and that, therefore, the second opinion medical report of Dr. Lieb will represent the weight of medical evidence in this case. The Office noted that further medical treatment was not authorized and prior authorization, if any, was terminated.

Appellant requested reconsideration and sent the Office another medical report from Dr. Ackerson dated November 17, 1997, in which Dr. Ackerson noted that he reviewed the history with appellant and reviewed the report of Dr. Lieb and still opined that the injuries to appellant's back and elbow were the result of direct trauma during the injury as outlined in the present illness. He continued:

> "While [appellant] does have some evidence of degenerative arthritis of the cervical spine, I feel that the findings are compatible with cubital tunnel syndrome and tardy ulnar nerve palsy. He has weakness of abduction of his fingers. [Appellant] does not have any clawing at present but he does have some weakness of his power grip. There is definite hypesthesia in the ulnar nerve distribution and most notably, an extremely positive Tinel's sign at the elbow**.** Just tapping lightly on his elbow reproduces the excruciating pain and discomfort in his left upper extremity. Furthermore, I steadfastly maintain that although his EMG has showed a slight bit of improvement, I feel this individual will continue to have trouble with his ulnar nerve and this is a relatively simple operation. It should be performed post haste and it seems that we are wasting very valuable time and that this will further jeopardize the outcome. Fortunately, his back is doing a little better. Furthermore, the individual has been working the entire time, much to my amazement and his credit."

By decision dated December 19, 1997, the Office found that the evidence submitted in support of reconsideration was cumulative and repetitive in nature and, therefore, was not sufficient for review of the case. In addition, the Office noted that Dr. Ackerson's medical opinion was based on appellant's subjective responses to physical medical tests and not on any objective medical findings and that he also did not provide any rationalized medical opinion to support his disagreement with the second opinion physician. Accordingly, appellant's request for reconsideration was denied.

The Board finds that the Office improperly terminated appellant's compensation.

Once the Office accepts a claim, it has the burden of proof to justify termination or modification of compensation benefits.[1] 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 disabling condition has ceased or that it is no longer related to the employment.[2] Thus, the burden of proof is on the Office rather than the employee with respect to the period subsequent to the date when compensation is terminated or modified.[3]

In the present case, the Office accepted appellant's claim for both low back strain and left cubital tunnel syndrome. Afterwards, there was a disagreement between appellant's treating physician, Dr. Ackerson, who determined that appellant suffered from a work-related injury to

[1] *Jacquelyn L. Oliver*, 48 ECAB 232 (1996).

[2] *Gwendolyn Merriweather*, 50 ECAB __ (Docket No. 97-2137, issued June 3, 1999).

[3] *Eddie Franklin*, 51 ECAB __ (Docket No. 98-1240, issued December 14, 1999).

his low back and that he continued to suffer from cubital tunnel syndrome causally related to his employment and Dr. Lieb, the physician the Office chose to render a second opinion, who determined that appellant's low back strain was resolved and that nonwork-related cervical radiculopathy was more likely the cause of appellant's current symptoms than cubital tunnel syndrome. When there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Office shall appoint a third physician who shall make an examination.[4]

In the case at hand, the Board finds that an outstanding conflict in medical opinion exists. Since the Office has not resolved the existing conflict in the medical evidence, it has failed to meet its burden of proof in terminating appellant's benefits.[5] To resolve this conflict in medical opinions, the Office should refer appellant, together with the medical record and a statement of accepted facts, to an appropriate specialist for an opinion on whether appellant has any residual disability causally related to his accepted injuries. After such further development of the evidence as it considers necessary, the Office shall issue an appropriate final decision on appellant's entitlement to compensation.

The decisions of the Office of Workers' Compensation Programs dated December 19 and November 19, 1997 are hereby set aside and the case is remanded for further proceedings consistent with this opinion.

Dated, Washington, D.C.
June 7, 2000

George E. Rivers
Member

Michael E. Groom
Alternate Member

Bradley T. Knott
Alternate Member

[4] 5 U.S.C. § 8123(a); *see also Gertrude T. Zakrajsek*, 47 ECAB 770, 773 (1996).

[5] *Mary A. Moultry*, 48 ECAB 566, 568-69 (1997).