U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of CATHERINE M. McCAULEY and DEPARTMENT OF THE NAVY, NAVAL RESEARCH LABORATORY, Washington, DC

Docket No. 99-1726; Submitted on the Record;
Issued September 20, 2000

DECISION and ORDER

Before DAVID S. GERSON, MICHAEL E. GROOM,
VALERIE D. EVANS-HARRELL

The issues are: (1) whether the Office of Workers' Compensation Programs met its burden of proof to terminate appellant's compensation effective November 7, 1996; and (2) whether appellant met her burden of proof to establish that she had any disability after November 7, 1996 causally related to her employment injury.

On August 7, 1995 appellant, then a 37-year-old secretary, sustained an employment-related lumbar contusion and cervical sprain when she slipped and fell in the ladies' room at work. She stopped work that day, returned to work four hours per day on September 18, 1995, stopped again on October 13, 1995, has not worked since and was placed on the periodic rolls. On June 21, 1996 the Office referred appellant, along with a statement of accepted facts, a set of questions and the medical record, to Dr. Arthur Kobrine, a Board-certified neurosurgeon, for a second opinion evaluation. By letter dated September 18, 1996, the Office informed her that it proposed to terminate her compensation, based on the opinion of Dr. Kobrine. Appellant submitted nothing further and, by decision dated November 7, 1996, the Office terminated her benefits effective that date on the grounds that she had no continuing employment-related residuals.

By letter dated May 13, 1997, appellant requested reconsideration and submitted additional medical evidence. In a July 8, 1997 decision, the Office denied modification of the prior decision. On November 6, 1997 she, through counsel, again requested reconsideration and submitted additional medical evidence. Based on the evidence submitted, the Office found that a conflict in the medical opinion existed between the opinions of Dr. Kobrine and Dr. Guy W. Gargour, appellant's treating Board-certified neurosurgeon, and on May 5, 1998 referred her, along with a statement of accepted facts, a set of questions and the medical record, to Dr. Michael W. Dennis, a Board-certified neurosurgeon, to resolve the conflict. By decision dated January 5, 1999, the Office denied modification of the prior decision, based on the opinion of Dr. Dennis, the impartial medical specialist. The instant appeal follows.

The medical evidence[1] relevant to the termination of appellant's compensation includes a March 6, 1996 magnetic resonance imaging (MRI) scan of the cervical spine, which demonstrated status post spinal fusion at C5-6. A March 14, 1996 MRI scan of the cervical spine demonstrated the previous spinal fusion and mild to moderate spondylitic change at C6-7 with moderate neural foraminal narrowing.

In an August 15, 1995 report, Dr. Daniel J. Bauk, appellant's treating orthopedic surgeon, advised that the symptoms in her neck and arm were most likely secondary to acute radiculopathy involving the C8 nerve root. Dr. Bauk continued to submit reports and on October 6, 1995 advised that appellant's condition was worsening. On October 24, 1995 he advised that she could work in a limited capacity and in an October 27, 1995 report, stated:

> "I told [appellant] that I have not found any objective finding concerning her neurologic exam[ination] consistent with radiculopathy that would be amenable to surgical intervention. I received the nerve conduction EMG [electromyogram] report which was read as showing left C8 and right C7 nerve root irritation with partial denervation changes; however, the changes appear to be relatively minor.

Dr. Bauk referred appellant to Dr. S. Krishna Nandipati, a Board-certified psychiatrist/neurologist who practices neurology. In a report dated October 16, 1995, Dr. Nandipati noted appellant's history of injury, her complaints of pain and numbness, and findings on examination. He diagnosed rule out cervical radiculopathy, cervical sprain and lumbar sprain and advised that appellant could not work. On November 1, 1995 Dr. Nandipati reported the electromyographic (EMG) findings of nerve root irritation at C8 on the left and on November 13, 1995 advised that appellant's MRI scan demonstrated no disc herniation or spinal stenosis. He continued to submit reports in which he noted findings on examination and advised that appellant could not work.

Dr. Gargour provided a report dated February 26, 1996. He noted the history of injury, and findings of decreased range of motion and exquisite superficial and deep tenderness over the lower cervical and upper thoracic midline. He advised that pressure over the midline caused pain and tingling in the fourth and fifth digits in both hands and reported some numbness in the infraclavicular area. Dr. Gargour continued:

> "Cervical MRIs reveal an old intrabody fusion at C5-6. I see no ruptured disc on the sagittal views. Although the transverse views go down to C7-T1, it is not a very good quality due to [appellant's] size and probably movement, but I see no obvious pathology."

His impression was cervical spine injury, possible ruptured disc at C7-T1 or T1-2.

In a March 26, 1996 report, Dr. Gargour reviewed the March 6, 1996 MRI scan of the cervical spine and advised that there was an indentation of the posterior dura at C5-6 and C6-7

[1] The record indicates that in 1988 appellant was in a nonwork-related motor vehicle accident in which she sustained a fractured vertebra at C6 for which she underwent spinal fusion.

with encroachment by the anterior fusion mass anteriorly, as demonstrated by the transverse views. He also opined that cervical spine x-rays indicated that the superior articular facet of C6 was encroaching on the neural foramen. Dr. Gargour concluded that appellant's problems appeared to be originating at the posterior cervical spine at the C5-6 and C6-7 levels and that the C8 nerve roots appeared to be involved "although there is no abnormality at C7-T1," stating that this could be due to a postfix brachial plexus. In an April 22, 1996 report, he diagnosed C8 radiculitis bilaterally, post-traumatic, left worse than right, rule out tethering of the spinal cord due to nerve root impingement and rule out epidural scarring. In a June 30, 1996 attending physician's report, he diagnosed bilateral cervical radiculitis and checked the "yes" box, indicating that appellant's condition was due to the August 7, 1995 employment injury.

By report dated May 1, 1996, Dr. Martin R. McLaren, a Board-certified anesthesiologist who evaluated appellant for pain management, noted the history of injury and appellant's complaints of severe neck pains with associated numbness and tingling in the arms and hands. Dr. McLaren noted findings on examination and diagnosed cervical radiculopathy at C7-T1 possibly secondary to postsurgical scarring with cervical facet syndrome. In a June 11, 1996 report, Dr. Baljeet S. Sethi, a Board-certified physiatrist, noted findings on examination and advised that, clinically, appellant presented with bilateral C8 radiculopathy, somewhat worse on the left, with no definite evidence of spinal cord compression.

Dr. Kobrine, a Board-certified neurosurgeon who provided a second opinion evaluation for the Office, provided a report dated July 22, 1996 in which he advised that he had reviewed the recent MRI scan which demonstrated excellent fusion at C5-6 with some chronic degenerative changes at C6-7. He stated:

> "Examination reveals a healthy appearing female who has limitation in range of motion of her neck because she complains of pain on attempting to move it. On palpation of any of the muscles in her cervical area or down her spine she cries out in pain. On attempt at neurological examination on any tightening up of her deltoid, biceps or triceps on either side she cries out in pain. I cannot detect any objective weakness of any of these muscle groups. Sensory exam[ination] is essentially normal although there are some patchy losses of light touch to subjective testing that range from minute to minute. Examination of the lower extremities reveals normal strength, tone, reflex and sensory exam[ination]. Straight leg raising causes back pain but no leg pain.
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> "I can find no objective neurological abnormalities in [appellant]. Furthermore her MRI shows a good fusion at C5-6 and evidence of chronic changes at C6-7 which are most likely due to her previous surgery at C5-6. It is my opinion that [she] probably did suffer some mild and temporary cervical strain from her fall in August 1995 but I find no evidence at this time for any persistent disability from this fall and consequently I would put no restriction on her activity or her employment at this time. It is further my opinion that she does not require any further medical treatment at this time."

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

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 was no longer related to the employment.[2]

In assessing medical evidence, the weight of such evidence is determined by its reliability, its probative value and its convincing quality. The factors which enter in such an evaluation include the opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of the analysis manifested and the medical rationale expressed in support of the physician's opinion.[3] In this case, the Board finds that the weight of the medical evidence regarding the termination of appellant's compensation rests with the opinion of Dr. Kobrine as he provided a comprehensive, well-rationalized report in which he explained his findings and conclusions. While the record contained EMG findings that indicated nerve root irritation at C8, appellant's MRI scan demonstrated no disc herniation or spinal stenosis. Drs. Gargour and McLaren indicated that appellant's condition was caused by encroachment from the fusion mass at C5-6 and C6-7. While Dr. Gargour checked the "yes" box on an Office form report indicating that appellant's condition was related to the August 7, 1995 employment injury, the Board has long held that when a physician's opinion on causal relationship consists only of checking "yes" to a form question, that opinion has little probative value and is insufficient to establish causal relationship.[4] The Board, therefore, finds that appellant had no employment-related disability on or after November 7, 1996, and the Office met its burden of proof to terminate her compensation benefits on that date.

The Board further finds that this case is not in posture for decision regarding appellant's disability after November 7, 1996.

As the Office met is burden of proof to terminate appellant's compensation benefits, the burden shifted to her to establish that she had continuing disability causally related to her accepted injury.[5]

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

[3] *Gary R. Sieber*, 46 ECAB 215 (1994).

[4] *See Ruth S. Johnson*, 46 ECAB 237 (1994).

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

Subsequent to the November 7, 1996 decision terminating her benefits, appellant submitted, *inter alia*,[6] deposition testimony dated June 10, 1997 in which Dr. Gargour noted that he began treating appellant on February 26, 1996 and advised that she sustained a vertical compression injury to her neck which led to increased narrowing of the lateral recesses at C6-7 and C7-T1 which produced chronic and persistent compression of the nerve roots exiting at those two levels. He continued that she then developed pain over the facet joints at these two levels, and finally developed, as a consequence of this prolonged injury, a chronic depression.

Dr. Gargour advised that the August 7, 1995 fall caused a laxity of appellant's cervical ligaments, which resulted in the lateral recess stenosis, explaining that this was caused by the ligaments becoming overstretched by the fall which led to narrowing and thus pinching the nerve. He advised that appellant's previous fusion produced increased stress on the levels above and below it which made them more fragile and therefore more vulnerable. An October 6, 1997 addendum to the MRI scan of the cervical spine dated March 14, 1996 demonstrated high-grade stenosis of the right C6-7 foramina with secondary soft disc herniation as well as spondylotic changes with mid and left parasagittal herniated nucleus pulposus and mild foraminal encroachment of the left. On October 8, 1997 Dr. Gargour performed cervical foraminotomy, laminotomy and plating at C6-7 and C7-T1 bilaterally.

The Office determined that a conflict in the medical opinion existed between the opinion of Drs. Kobrine and Gargour regarding whether appellant continued to be disabled. The Office then referred her to Dr. Michael W. Dennis, a Board-certified neurosurgeon, for an impartial medical evaluation.

In a May 20, 1998 report, Dr. Dennis related the history of appellant's 1988 and 1995 injuries. He concluded:

> "With reference to [appellant's] present complaints, it would appear that [her] low back pain has resolved; that she has persistent cervical compliances [*sic*] with evidence of restriction of range of motion of the neck. It would appear that [her] symptoms are the result of degenerative changes of the neck at the C6-7 level and C7-T1 level with a work injury superimposed on that degenerative condition. It would appear that the degenerative condition was made symptomatic by the fall but not aggravated by the fall in the sense that there was no alteration in serial MRI scans. At the present time, given [her] physical findings, I believe that [she] would have the capacity to function in sedentary light occupations where prolonged static positions, reaching above shoulder level, sustained work at shoulder level or lifting, carrying in excess of 10 pounds are avoided. At this point, I would not believe that [she] requires any further treatment since I believe

[6] Appellant also submitted reports that were previously of record and/or were not relevant to her condition after November 7, 1996. She also submitted a November 10, 1995 MRI scan of the cervical spine that was read as showing no significant disc herniation or canal stenosis, a March 21, 1997 report from Dr. Howard M. Haft, a Board-certified internist, and an EMG report dated November 24, 1997 which revealed nerve root irritation at C7 on the left with partial denervation changes and reports from Dr. Gargour dated December 23, 1996, February 11, June 17 and October 16, 1997.

that [her] condition is permanent and stationary and it is unlikely to respond to treatment or unlikely to improve."

In situations where there are opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[7] However, when the Office secures an opinion from an impartial medical specialist for the purpose of resolving a conflict in medical opinion evidence and the opinion from such specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the impartial specialist for the purpose of correcting the defect in the original report.[8]

In this case, in his May 20, 1998 report, Dr. Dennis advised that appellant's symptoms were the result of degenerative changes of the neck at the C6-7 level and C7-T1 level with the August 7, 1995 work injury superimposed on that degenerative condition which made her symptomatic. Therefore, as Dr. Dennis advised that the employment injury caused appellant to become symptomatic and that she could only perform sedentary work, the case will be remanded for the Office to prepare an updated statement of accepted facts, containing a position description of the secretarial job that appellant was performing on October 13, 1995 to include the physical requirements of the job. The Office should then obtain a supplemental report from Dr. Dennis.[9] After such development as it deems necessary, the Office shall issue a *de novo* decision.[10]

[7] *See Kathryn Haggerty*, 45 ECAB 383 (1994); *Edward E. Wright*, 43 ECAB 702 (1992).

[8] *See Talmadge Miller*, 47 ECAB 673 (1996).

[9] The Board notes that, when the impartial medical specialist's statement of clarification or elaboration is not forthcoming to the Office, or if the physician is unable to clarify or elaborate on the original report, or if the physician's report is vague, speculative or lacks rationale, the Office must refer the employee to another impartial specialist for a rationalized medical opinion on the issue in question.

[10] The Board notes that medical reports that are unsigned are of diminished probative value. *See Diane Williams*, 47 ECAB 613 (1996).

The decision of the Office of Workers' Compensation Programs dated January 5, 1999 is affirmed in part and vacated in part, and the case is remanded to the Office for proceedings consistent with this opinion.

Dated, Washington, DC
September 20, 2000

David S. Gerson
Member

Michael E. Groom
Alternate Member

Valerie D. Evans-Harrell
Alternate Member