U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of MARTIN F. GARCIA and DEPARTMENT OF THE NAVY, MARINE CORPS LOGISTICS BASE, Barstow, CA

Docket No. 00-2107; Submitted on the Record;
Issued August 29, 2001

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS, MICHAEL E. GROOM

The issues are: (1) whether the Office of Workers' Compensation Programs met its burden of proof to establish that appellant no longer suffered residuals of his lumbar spine and left pelvis conditions; and (2) whether appellant has met his burden of proof to establish that his right wrist and right shoulder conditions are causally related to the February 5, 1996 employment injury.

On February 5, 1996 appellant, then a 51-year-old painter, fell from a scaffold. The Office accepted his claim for right elbow fracture with open reduction and hardware removal, left hip contusion and left hip fracture.[1] He stopped work that day and received compensation benefits.

The Office referred appellant, together with the medical record and a statement of accepted facts, to Dr. Russell F. Compton, a Board-certified orthopedic surgeon, for an opinion on what diagnosed conditions were medically connected to the employment incident of February 5, 1996. In a report dated May 25, 1997, Dr. Compton related appellant's history and complaints and summarized the medical record. He described his findings on physical examination and diagnosed the following: status post open reduction internal fixation, comminuted fracture, olecranon, right elbow, February 5, 1996; status post removal of metal, right elbow, December 17 1996; healed fracture, left pubic ramus; disc bulge L3-4, L4-5 and L5-S1, per computerized tomography (CT) scan, lumbar spine, February 8, 1996; and cervical spondylosis, by x-ray. Dr. Compton reported that the cause of appellant's current disability was the work-related injury of February 5, 1996 and that there was no nonindustrial orthopedic disability present. He stated that apportionment was not indicated because there was no history of right elbow or back problems prior to the February 5, 1996 injury: "The current diagnosed orthopedic conditions are medically connected to the injury event of February 5, 1996 by direct

[1] This information appears in the Office's statement of accepted facts dated April 22, 1997.

cause, from a fall from an eight feet scaffold." On the issue of preexisting conditions, Dr. Compton reported as follows:

> "Based on radiographic findings, dated February 5, 1996, [appellant] has moderate spondylosis involving the lower half of the cervical spine. He also had a CT scan of the lumbar spine, dated February 8, 1996 consistent with degenerative conditions. These are in my opinion preexisting conditions, which had been temporarily aggravated on February 5, 1996. He continues to be symptomatic as regards to the neck and the lower back; however, objective findings on physical examination are nonexistent."

Dr. Compton expected that appellant's work-related conditions would resolve within approximately six months.

The record indicates that the Office expanded the accepted conditions to include disc bulge L3-S1.

In a report dated February 12, 1998, appellant's attending physician, Dr. Rama T. Pathi, a Board-certified orthopedic surgeon, requested that the Office approve appellant's low back condition:

> "[Appellant] has been complaining of pain in the lower back since the injury. As you are aware, the injury occurred from a fall from a height with a vertical landing which characteristically affects the lower back. He had x-rays performed immediately after the injury at the hospital. However, there has been no follow-up approval for the back evaluation. Based on the history and initial hospital evaluation, the current low back pain is directly related to the fall described above. Our office is requesting approval for evaluation and treatment of the low back."

After receiving a recommendation that appellant undergo cervical spine surgery, the Office requested an opinion from its medical adviser. The Office informed the medical adviser that the accepted conditions were cervical spondylosis, right elbow fracture with reduction and eventual removal of plate, left hip contusion, disc bulge L3-S1, intervertebral osteochondrosis L1-3 and pelvis fracture. The Office asked its medical adviser whether it should expand the work-related conditions to include protruded and bulging discs at C3-6 and whether surgery should be approved. The medical adviser replied on September 15, 1998 that it was possible the fall caused some aggravation of the preexisting cervical spondylosis but that the second opinion physician in May 1997 felt these were preexisting degenerative changes. Copies of the diagnostic tests were needed, he advised, and a new second opinion might ultimately still be needed.

The Office prepared a statement of accepted facts dated February 1, 1999. The Office related appellant's history of injury and stated that it had accepted the following conditions: right elbow fracture with subsequent surgery; left hip contusion; disc bulges at L3-S1; left pelvis

fracture with surgery;[2] degenerative disc disease of the lumbar spine; cervical spondylosis; intervertebral osteochondrosis; osteophytes at L1-3 and mild retrolisthesis at L2-3.[3]

The Office referred appellant, together with the medical record and this statement of accepted facts, to Dr. Thomas R. Dorsey, a Board-certified orthopedic surgeon, and Dr. Jay Jurkowitz, a Board-certified neurologist, for an opinion on which conditions were currently related to the February 5, 1996 employment injury and whether cervical spine surgery was necessary.

In a report dated March 2, 1999, Dr. Dorsey related appellant's complaints and history. He reviewed the medical records submitted and summarized the significant objective information. Dr. Dorsey described his findings on physical examination and offered the following diagnoses: cervical spinal stenosis; degenerative disc disease, lumbar spine; degenerative facet disease, lumbar spine; left hip contusion, resolved, but with residual greater trochanteric tendinitis; right shoulder impingement syndrome; left superior and inferior pubic ramus fracture of the pelvis, healed, without residual; status post open reduction and internal fixation, right elbow olecranon fracture, intra-articular, February 7, 1996; and status post hardware removal, right elbow, December 17, 1996.

The Office explained to Dr. Dorsey that it needed to know if it should accept as industrial any further conditions or make findings that some of the conditions are no longer industrial. Dr. Dorsey replied as follows:

> "The right elbow condition, in my opinion is directly related to the events of February 5, 1996. With regard to his other complaints, I do not see evidence of relationships to the February 5, 1996, episode. With regard to the pelvis, although there was a pelvis fracture, these fractures are healed, and there is no evidence of any residual.

[2] Appellant did not undergo surgery for his left pelvis fracture.

[3] The Office's nonfatal summary, Form CA-800, reflected all of these accepted conditions at one point in time. Original entries under "conditions caused by injury" appear to include right elbow fracture and left hip contusion. These entries are dated and initialed. Left pelvis fracture was added at some later time, but the form does not indicate when or by whom. Open reduction was added next to the entry for right elbow fracture, together with another entry that has since been whited out and cannot be read. Also added to the conditions caused by injury were disc bulges L3-4 and L5-S1 and plate removal, right elbow, the latter of which is dated December 17, 1996. It then appears that a claims examiner crossed out the heading "Concurrent disability not due to injury" and used the needed space below to continue listing the conditions caused by injury. Here were added degenerative disc disease of lumbar spine and cervical spondylosis. These entries were amended at some point to indicate temporary aggravations. Next to these appear entries that were whited out but are still legible: intervertebral osteochondrosis, osteophytes L1-2 and L2-3, and mild retrolisthesis, L2-3. The Office's nonfatal summary has been so altered at unknown times and by unknown people (not to mention that the record contains only a photocopy of the document and not the original) that the Board will depend on more reliable evidence in the case record to determine what conditions the Office accepted as resulting from the February 5, 1996 employment injury. The statement of accepted facts dated February 1, 1999, which the Office prepared to give its referral physicians an accurate factual framework, is persuasive evidence of the conditions accepted at that time.

"With regard to the contusion of the left hip, the patient is showing, at this time, greater trochanteric tendinitis, which would be considered a residual of his left hip contusion.

"With regard to the right shoulder, there is evidence of impingement syndrome, which is not a traumatic condition, but is a degenerative condition. Therefore, there is no relationship to the events of February 5, 1996. There was no evidence of fracture or permanent damage to the right shoulder as a result of the events of February 5, 1996.

"With regard to the upper extremity pain, both on the left and on the right, the patient is showing evidence of cervical spinal stenosis. This, in my opinion, was not caused by or materially exacerbated, accelerated or aggravated by the evidence of February 5, 1996. The events of February 5, 1996, would have resulted in cervical musculoligamentous sprain/strain. I see no evidence of fracture or neurologic involvement in the cervical spine as a result of the episode of February 5, 1996; however, there is a significant degenerative condition of the cervical spine, consisting of cervical spinal stenosis, as evidenced by retrolisthesis, spondylosis, and osteophytes seen in the cervical spine.[4] This is a degenerative condition as opposed to an acute traumatically-caused condition."

On the issue of continuing residuals, Dr. Dorsey reported as follows:

"There are continuing medical residuals of the claimant's work injury. These consist of his right elbow condition. There is diffuse tenderness posteriorly at the elbow. There is positive lateral epicondyle tenderness, which is nonindustrial; however, there is decreased range of motion in extension of the left elbow. There was an intra-articular fracture of the olecranon, status post fixation. I do not have a recent x-ray of the elbow, but it is likely that there is some arthritis in this elbow, since it was an intra-articular fracture. The patient also has residuals of greater trochanteric tendinitis of the left hip. I do not see any residuals with regard to the cervical spine or the lumbar spine."

Dr. Dorsey reported that appellant was unable to do his date-of-injury job as a painter but recommended no further treatment.

In a report dated March 18, 1999, Dr. Jurkowitz related appellant's history and complaints. He, too, summarized the medical record and described his findings on physical and neurological examination. After reporting the results of electrodiagnostic studies, Dr. Jurkowitz diagnosed the following: generalized polyneuropathy with hammertoes, nonindustrial and probably familial; cervical spine stenosis with myelopathy on MRI via sensory level at T1 or T2 of the neurological examination, bilaterally; and lumbosacral degenerative disc disease with some radicular symptoms, but no evidence of local nerve root involvement, at this time. Dr. Jurkowitz reported that while there was no clear cut evidence of radiculopathy, "there very

[4] Dr. Dorsey explained that intervertebral osteochondrosis, retrolisthesis, spondylosis and osteophytes are all radiographic phenomena seen in degenerative disc disease and degenerative joint disease of the cervical spine.

well may be evidence of myelopathy with spinal cord involvement from the February 5, 1996, injury." With respect to further treatment, he reported:

> "The patient actually has been relatively stable for a while now and is able to do his light-duty work. However, the MRI scan is very compelling as to the degree of pressure on the spinal cord. Since I do believe that he has symptoms due to myelopathy, the possibility of surgery, that is fusion of the cervical spine, is certainly a reasonable option at this time. There is no other particular therapy to help relieve the pressure on the spinal cord."

In a supplemental report dated July 28, 1999, Dr. Dorsey provided the following clarification:

> "The basis of my opinion that the patient no longer suffers residuals of his industrial lumbar condition is the following: radiographs of February 5, 1996 of the lumbar spine, on the date of injury, showed no evidence of fracture, subluxation or acute abnormality. CT scan of the lumbar spine three days following the episode, that is, February 8, 1996, showed no evidence of acute herniated nucleus pulposus, fracture or instability. This showed only minimal broad-based disc bulge at the L4-5 disc level with mild compromise of the inferior aspect of the left and right middle foramina. This is not an acute finding.
>
> "Additionally, on my examination of March 2, 1999 the patient showed no evidence of neurologic impingement in the lumbar spine. Additional information that can be added at this time is that Dr. Jurkowitz saw the patient on March 18, 1999 and found lumbar degenerative disc disease, but no evidence of local nerve root involvement.
>
> "All of this information points to the conclusion that the patient, at most, would have suffered a lumbar contusion and/or musculoligamentous sprain/strain on February 5, 1996.
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> "The known history of resolution of lumbar musculoligamentous sprain/strain is that of complete resolution within 30 days. This also applies to the condition of contusion.
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> "There was, therefore, no basis at the time of my examination, March 2, 1999, on which to conclude that the patient had any industrial lumbar residual."

On July 30, 1999 Dr. Pathi related his findings on examination and diagnosed the following: post-traumatic arthritis, right elbow, status post complex fracture; tendinitis, left hip, status post extensive soft tissue contusion; status post pubic rami fracture; rotator cuff tendinitis, right shoulder; cervical traumatic myofascitis with preexisting cervical spinal stenosis; and traumatic low back myofascitis with discogenic disease. Dr. Pathi reviewed Dr. Dorsey's March 2, 1999 report and commented as follows:

> "Records from March 2, 1999 from Thomas Dorsey: The patient was diagnosed with cervical spine stenosis, cervical degenerative disc disease and degenerative

facet disease with trochanteric tendinitis. He was also diagnosed to have cervical spine impingement and left superior and inferior pubic rami fracture. He also had diagnosis of post fixation of the right elbow fracture.

"As far as the causation, it was noted that the right elbow was directly related to the February 5, 1996 injury. [Appellant] had cervical spine as well as lumbar spine x-rays performed on the day of injury to the pain in the above-mentioned areas. The x-rays did not reveal any fracture or dislocations. There was soft tissue ligamentous traumatic myofascitis, which occurred as a result of the above accident. The osteoarthritis and spondylosis are of course preexisting and not directly related to the injury; however, the traumatic cervical ligamentous and soft tissue injury to the back and the neck were directly related to the February 5, 1996 injury. The left hip revealed a huge hematoma, which lasted for months, resulting in post-traumatic bursitis, resulting in residual symptoms. This again is work related; however, there is no need for surgery as of this evaluation. The patient may require to have possible cortisone injection.

"Evaluation of records from Dr. Jurkowitz of March 18, 1999. The EMG nerve conduction studies revealed myelopathy, cervical disc disease and lumbar disc disease. The diagnosis of polyneuropathy with hammer toes on an industrial basis; cervical spine stenosis with myelopathy; rule out sensory loss at level T1-2 bilaterally; lumbosacral degenerative disease with some radicular symptoms, but no evidence of any local nerve root involvement at this time.

"As far as causation, Dr. Jurkowitz indicated that there may very well be evidence of myelopathy with spinal cord involvement from the February 5, 1996 injury.

"Since [appellant] denies any prior symptoms in his neck or back, and there is no evidence of any fracture dislocation on the x-rays or MRI of the cervical and lumbar spine, there may be the need for apportionment. The preexisting spondylosis of the cervical as well as lumbar spine and degenerative disc disease and spinal stenosis are preexisting and nonindustrial related; however, the acute symptoms of soft tissue and ligamentous symptoms are from the trauma."

On September 28, 1999 the Office issued a notice of proposed termination of compensation for the temporary aggravation of the preexisting degenerative disease at L3-4, L4-5 and L5-S1 and for the left pelvis fracture because the medical evidence indicated that appellant no longer suffered work-related residuals of these conditions.[5] The Office found that a conflict in medical opinion existed on whether appellant's cervical condition was related to the February 5, 1996 employment injury and stated that a referee medical examination would be scheduled to resolve the matter. The Office noted that it should accept that appellant sustained a minor abrasion to the head and a cut to the shin, as this was consistent with appellant's claim and the ambulance report. The Office noted, on the other hand, that it should not accept a right wrist

[5] That the Office issued a formal notice to terminate benefits for a temporary aggravation of preexisting degenerative disc disease at L3-S1 is compelling evidence that the Office had earlier accepted this condition as employment related.

condition as there was no medical evidence diagnosing the condition or relating it to the incident of February 5, 1996. The Office also noted that it should not accept a right shoulder condition; Dr. Dorsey offered the only rationalized opinion on the matter and found it to be nonindustrial. The Office concluded that the file should reflect the following accepted conditions: status post open reduction and internal fixation, right elbow olecranon fracture; and left hip contusion, resolved, but with greater trochanter tendinitis. Because appellant continued to suffer residuals of these conditions, the Office found that the file should remain open for medical treatment.

In a decision dated November 1, 1999, the Office terminated compensation benefits for the lumbar spine and left pelvis on the grounds that the weight of the medical evidence, as represented by the opinion of Dr. Dorsey, established that appellant no longer suffered work-related residuals of these conditions.

The Office issued a separate decision on November 1, 1999 denying appellant's claim for a right wrist and right shoulder condition. The Office found that the evidence of record was insufficient to establish that these conditions were causally related to the employment incident of February 5, 1996.

Appellant requested a review of the written record.

In a decision dated March 28, 2000, an Office hearing representative affirmed both decisions dated November 1, 1999. The hearing representative found that the weight of the medical evidence rested with Dr. Dorsey and established that residuals of appellant's low back condition and left pelvis condition had ceased. The hearing representative also found that appellant failed to submit rationalized medical evidence establishing that his right wrist and right shoulder conditions were causally related to the employment injury.

The Board finds that the Office has not met its burden of proof to establish that appellant no longer suffered residuals of his lumbar spine condition.

Once the Office accepts a claim, it has the burden of proof to justify termination or modification of compensation benefits.[6] 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.[7]

The Office found that the weight of the medical evidence rested with Dr. Dorsey, the Board-certified orthopedic surgeon and Office referral physician. On March 2, 1999 Dr. Dorsey diagnosed, among other conditions, degenerative disc disease, lumbar spine and degenerative facet disease, lumbar spine. He stated: "I do not see any residuals with regard to the cervical spine or the lumbar spine." Asked to clarify, Dr. Dorsey explained on July 28, 1999 that appellant no longer suffered residuals of his industrial lumbar condition for several reasons:

[6] *Harold S. McGough*, 36 ECAB 332 (1984).

[7] *Vivien L. Minor*, 37 ECAB 541 (1986); *David Lee Dawley*, 30 ECAB 530 (1979); *Anna M. Blaine*, 26 ECAB 351 (1975).

Radiographs of the lumbar spine on the date of injury showed no evidence of fracture, subluxation or acute abnormality. A CT scan of the lumbar spine three days later showed no evidence of acute herniated nucleus pulposus, fracture or instability, only minimal broad-based disc bulge at the L4-5 disc level with mild compromise of the inferior aspect of the left and right middle foramina. Dr. Dorsey noted that this was not an acute finding. He also noted no evidence of neurologic impingement in the lumbar spine on his examination of appellant on March 2, 1999. Further, although Dr. Jurkowitz, the Board-certified neurologist and Office referral physician, found lumbar degenerative disc disease, he found no evidence of local nerve root involvement. At most, Dr. Dorsey concluded, appellant would have suffered a lumbar contusion or musculoligamentous sprain/strain on February 5, 1996, the known history of resolution of which was complete resolution within 30 days.

Dr. Dorsey's reasoning does not address whether appellant continues to suffer residuals of the accepted disc bulges at L3-S1 or the accepted degenerative disc disease of his lumbar spine, temporarily aggravated or otherwise; his reasoning instead attempts to explain that these conditions were never related to appellant's employment. His opinion is that appellant would have suffered at most a lumbar contusion or musculoligamentous sprain/strain on February 5, 1996. Dr. Dorsey's major premise, therefore, is inconsistent with the statement of accepted facts dated February 1, 1999, which the Office instructed him to use as his sole factual frame of reference. While he is free to express his professional opinion and the reasons he came to his conclusion, it is error for the Office to use such an opinion to terminate compensation benefits on the grounds that appellant no longer suffers residuals of his accepted lumbar spine condition. Dr. Dorsey does not accept that appellant's disc bulges or degenerative disc disease were related to the February 5, 1996 employment injury, and so his opinion provides an insufficient basis for the termination of benefits for the accepted lumbar spine conditions. The Board will reverse the Office's March 28, 2000 decision insofar as it affirmed the termination of compensation benefits for the accepted lumbar spine conditions.

The Board finds that the Office has met its burden of proof to terminate benefits for the accepted condition of left pelvis fracture.

Dr. Dorsey diagnosed left superior and inferior pubic ramus fracture of the pelvis, healed, without residual. He reported: "With regard to the pelvis, although there was a pelvis fracture, these fractures are healed and there is no evidence of any residual." There is no disagreement from the other physicians of record. The fracture was reported to be healed as early as August 1996 with no findings of abnormality. On this point the Office has met its burden of proof. The Board will affirm the Office's March 28, 2000 decision insofar as it affirmed the termination of compensation benefits for the accepted left pelvis fracture.

The Board notes that the accepted left pelvis fracture is distinct from the accepted left hip contusion, which has left residuals of greater trochanteric tendinitis. The Office accepts this residual and is keeping appellant's file open for medical treatment of such.

The Board also finds that appellant has not met his burden of proof to establish that his right wrist and right shoulder conditions are causally related to the February 5, 1996 employment injury.

A claimant seeking benefits under the Act[8] has the burden of proof to establish the essential elements of his claim by the weight of the evidence,[9] including that he sustained an injury while in the performance of duty and that any specific condition or disability for work for which he claims compensation is causally related to that employment injury.[10]

The Office, of course, accepts that appellant sustained an injury in the performance of duty on February 5, 1996. It is appellant's burden to establish that his right wrist and right shoulder conditions are causally related to that employment injury.

The evidence generally required to establish causal relationship is rationalized medical opinion evidence. The claimant must submit a rationalized medical opinion that supports a causal connection between his current condition and the employment injury. The medical opinion must be based on a complete factual and medical background with an accurate history of the claimant's employment injury and must explain from a medical perspective how the current condition is related to the injury.[11]

Appellant has submitted no such medical opinion evidence to support that his right wrist and right shoulder conditions are causally related to the February 5, 1996 employment injury. His attending orthopedic surgeon, Dr. Pathi, reported on July 30, 1999 that appellant had rotator cuff tendinitis, right shoulder, but he offered no opinion, much less a well-reasoned medical opinion, on whether this condition was a result of appellant's fall on February 5, 1996. Dr. Pathi made no mention of a right wrist condition.

In his March 2, 1999 report, Dr. Dorsey noted that there was evidence of impingement syndrome in the right shoulder but that this was a degenerative condition, not a traumatic condition. There was no evidence of fracture or permanent damage to the right shoulder as a result of the events of February 5, 1996. Dr. Dorsey therefore concluded that there was no relationship to the events of February 5, 1996.

The record lacks a well-reasoned medical opinion explaining how appellant's fall on February 5, 1996 caused appellant's right wrist or right shoulder condition, it contains a reasoned medical opinion negating any causal relationship between appellant's right shoulder condition and the fall on February 5, 1996. The weight of the evidence therefore fails to establish that appellant's right wrist and right shoulder conditions are causally related to the February 5, 1996 employment injury. The Board will affirm the Office's March 28, 2000 decision insofar as it denied compensation benefits for the claimed right wrist and right shoulder conditions.

The Office has issued no decision on the accepted cervical spondylosis condition. There was some disagreement between the Office referral physicians, Drs. Dorsey and Jurkowitz, on

[8] 5 U.S.C. §§ 8101-8193.

[9] *Nathaniel Milton*, 37 ECAB 712 (1986); *Joseph M. Whelan*, 20 ECAB 55 (1968) and cases cited therein.

[10] *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[11] *John A. Ceresoli, Sr.*, 40 ECAB 305 (1988).

whether appellant's cervical condition was related to the events of February 5, 1996. The Office has indicated that it will further develop the medical evidence on this point.

Finally, the Board notes that Drs. Dorsey and Pathi appear to agree that appellant sustained a cervical and lumbar soft tissue injury as a result of his fall on February 5, 1996. Dr. Dorsey reported that the events of February 5, 1996 would have resulted in cervical musculoligamentous sprain/strain. In less certain language he stated that appellant would have suffered "at most" a lumbar contusion or musculoligamentous sprain/strain on February 5, 1996. Dr. Pathi reported that there was soft tissue ligamentous traumatic myofascitis that occurred as a result of the incident. In his opinion, the osteoarthritis and spondylosis were preexisting and not directly related to the injury; however, the traumatic cervical ligamentous and soft tissue injury to the back and the neck were directly related to the February 5, 1996 injury. Dr. Pathi further reported that the preexisting spondylosis of the cervical as well as lumbar spine and degenerative disc disease and spinal stenosis were preexisting and nonindustrial related; however, the acute symptoms of soft tissue and ligamentous symptoms were from the trauma. Dr. Pathi diagnosed the cervical and lumbar soft-tissue conditions as myofascitis. The Office should decide whether the medical evidence is sufficient to establish that appellant sustained a soft tissue injury to the cervical and lumbar regions as a result of his February 5, 1996 fall.

The March 28, 2000 decision of the Office of Workers' Compensation Programs is reversed on the issue of termination for the accepted lumbar spine conditions and is otherwise affirmed.

Dated, Washington, DC
August 29, 2001

David S. Gerson
Member

Willie T.C. Thomas
Member

Michael E. Groom
Alternate Member