U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of EVEREST M. BAILEY and U.S. POSTAL SERVICE,
APOPKA POST OFFICE, Apopka, FL

Docket No. 99-2486; Submitted on the Record;
Issued June 1, 2001

DECISION and ORDER

Before DAVID S. GERSON, BRADLEY T. KNOTT,
A. PETER KANJORSKI

The issue is whether the Office of Workers' Compensation Programs properly terminated appellant's compensation effective February 17, 1998.

On October 15, 1990 appellant, then a 36-year-old part-time rural letter carrier, picked up two tubs of mail and placed them on his stool when he felt something snap in his back and developed low back pain. He stopped working that day. In a November 8, 1990 report, Dr. Robert H. Shear, a Board-certified neurosurgeon, indicated that appellant reported prior back surgery in 1972. He noted appellant had some tenderness over the left sciatic notch, decreased sensation in the dorsum of the left foot and lateral left lower leg and good muscle strength in the legs. In a November 13, 1990 report, Dr. Kenneth L. Margeson, a Board-certified radiologist, indicated that a magnetic resonance imaging (MRI) scan showed former surgery and bulging discs at L4-5 and L5-S1. He found no herniated discs.

The Office accepted appellant's claim for low back strain and aggravation of a degenerative back condition. Appellant received continuation of pay for the period October 16 through November 29, 1990. The Office began payment of temporary total disability compensation effective November 30, 1990.

In a January 10, 1991 report, Dr. Stacy J. Berckes, a Board-certified anesthesiologist, related that appellant had undergone a lumbar laminectomy. He diagnosed low back syndrome, left leg pain and post laminectomy syndrome with adhesive arachnoiditis, which might have been exacerbated, causing the other conditions. Dr. Berckes indicated that appellant could return to light-duty work. Appellant returned to light-duty work on March 19, 1991 and subsequently increased his work duties to the point that he was working 40 hours a week.

On May 1, 1995 appellant filed a claim for a recurrence of disability. He indicated that he stopped working on April 10, 1995. Appellant stated that he had been able to work full time with a 20-pound lifting restriction. He commented, however, that he had been in pain every day since the October 15, 1990 employment injury. On July 20, 1995 appellant filed a claim for low

back syndrome, radiculopathy and degenerative disc disease. Appellant stated that excessive heat or cold, dampness, or high-speed working would aggravate his back pain. He noted that his job required reaching above the shoulder, walking, lifting, bending, squatting, climbing, kneeling, twisting, standing and driving 72 miles a day commuting to and from work and 132 miles a week delivering mail.

In an April 21, 1995 report, Dr. Susan Rebsamen, a Board-certified radiologist, indicated that an MRI scan showed degenerative disc disease at the L4-5 and L5-S1 levels. She commented that the small right paracentral disc herniation seen on the 1990 MRI scan, was not well visualized on the current MRI scan. Dr. Rebsamen noted that the current MRI scan showed a left surgical defect at L5-S1 with enhancing scar tissue at the periphery of a small central nonenhancing defect. She reported that the scar tissue abutted the descending right and left S1 nerve root sleeve. Dr. Rebsamen suggested that the nonenhancing defect might be a small residual disc herniation or a small end plate spur.

In a September 24, 1995 decision, the Office denied appellant's claim for compensation on the grounds that the evidence of record failed to demonstrate a causal relationship between the employment and appellant's condition or disability. In an October 19, 1995 decision, the Office vacated its September 24, 1995 decision and accepted appellant's claim for compensation. The Office began payment of temporary total disability compensation effective May 1, 1995.

In a February 22, 1996 letter, the employing establishment offered appellant a position as a modified part-time flexible clerk. In a March 11, 1996 letter, the Office informed appellant that it found the job suitable for him and warned him that a refusal to accept the offered position without a justified reason would result in the termination of compensation. In an August 20, 1996 letter, the Office informed appellant that it had reviewed his reasons for not accepting the position and found them unjustified. He was given 15 days to accept the position or his compensation would be terminated.

In a November 13, 1996 decision, the Office terminated appellant's compensation for refusal to accept suitable employment. In a December 13, 1996 letter, appellant requested a review of the written record by an Office hearing representative. In a March 11, 1997 decision, the Office hearing representative found that there existed a conflict in the medical evidence on whether appellant could perform the duties of the offered position and whether he had any residuals of the October 15, 1990 employment injury which affected his ability to work. She, therefore, set aside the Office's November 13, 1996 decision, ordered reinstatement of compensation and instructed the Office to refer appellant to an appropriate medical specialist to determine whether appellant had any residuals of the employment injury and, if so, describe his work limitations.

In a February 17, 1998 decision, the Office terminated appellant's compensation effective that date on the grounds that appellant had recovered from his October 15, 1990 employment injury. Appellant requested a hearing before an Office hearing representative, which was conducted on January 26, 1999. In an April 26, 1999 decision, which became final on April 28, 1999 a second Office hearing representative affirmed the Office's decision to terminate appellant's compensation.

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 August 30, 1995 report, Dr. Donald J. Tindall, Board-certified in emergency medicine, stated that he had been treating appellant for chronic back pain since December 26, 1990. He commented that appellant's back pain had been controlled at a tolerable level until April 1985 when he complained of an exacerbation of his back pain. Dr. Tindall noted that appellant, at that time, was working as a regular mail carrier, which involved considerable lifting and bending. He concluded that appellant's exacerbation was job related, due to the frequent lifting and bending.

In a March 27, 1996 report, Dr. Larry R. Sadler, a Board-certified radiologist, indicated that a myelogram showed a shallow L4-5 ventral extra-dural impression and decreased filling at the S1 nerve root sleeve. He indicated that a computerized tomography (CT) scan showed the previous L5-S1 hemilaminectomy. Dr. Sadler also noted a central to left L5-S1 herniated nucleus pulposus (HNP). He commented that the mass effect on the right S1 nerve root sleeve was more suggestive of a HNP. Dr. Sadler stated that appellant also had a diffuse L4-5 posterior annular bulge with shallow superimposed central to right-sided HNP. He also noted a very shallow left paracentral, L3-4 bulge or HNP.

The Office referred appellant, together with a statement of accepted facts and the case record, to Dr. J. Darrell Shea, a Board-certified orthopedic surgeon, for an examination and second opinion. In a May 2, 1996 report, he indicated that appellant had altered sensation in the lateral aspect of the left leg below the knee. Dr. Shea found general weakness in the left leg. Dr. Shea noted that x-rays showed a laminectomy defect at L5-S1 on the left. He reported that a myelogram and computerized tomography (CT) scan showed an apparent bulging herniated L5-S1 disc centrally and slightly to the left. Dr. Shea diagnosed status postoperative lumbar laminectomy, L5-S1 and back and bilateral leg pain, possibly secondary to a recurrent HNP. He recommended an electromyogram (EMG) and nerve conduction studies of the legs.

In a May 7, 1996 report, Dr. Tindall stated, appellant had back pain that radiated down to both feet. He reported that Achilles deep tendon reflexes were absent bilaterally. Dr. Tindall found no motor deficit of the legs but did find mild decreased sensation over the lateral aspect of the thighs and calves bilaterally. He indicated appellant had paraspinous tenderness from L5 to S3 with multiple points of tenderness, which caused pain in both legs when palpated. Dr. Tindall diagnosed chronic low back pain, mostly multifactorial in origin, which included myofascial pain and degenerative disc disease. He recommended that appellant return to work to see if he could tolerate the pain. Dr. Tindall noted that appellant's commute of 45 to 50 minutes each way could aggravate his back pain. He commented that the problem had not been solved.

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

In a June 3, 1996 report, Dr. Matthew D. Imfeld, a Board-certified physiatrist, stated that appellant had minimally abnormal nerve conduction studies and EMG consistent with a left S1 radiculopathy of indeterminant old age. He commented that he did not find any evidence of acute injury. He indicated that there was no evidence of a right lumbosacral radiculopathy or plexopathy, or evidence of peripheral neuropathy.

The Office requested an updated assessment from Dr. Shea. In a September 9, 1996 report, Dr. Shea noted appellant's medical history of the lumbar laminectomy in 1972 and the employment injury of October 15, 1990, which had been accepted as a lumbar strain and aggravation of degenerative disc disease. He concluded that the lumbar strain related to the employment injury had resolved. Dr. Shea indicated appellant should be able to return to a light-duty job which required no repetitive bending, lifting or stooping and no lifting over 25 pounds. He stated that the lumbar laminectomy at L5-S1 was not related to the lumbar strain.

In a November 14, 1996 report, Dr. R.W. Springstead, a Board-certified orthopedic surgeon, diagnosed multiple herniated lumbar discs, a herniated C6-7 disc, degenerative disc disease of the lumbar spine and cervical spondylosis. He concluded appellant was disabled from work. Dr. Springstead, however, did not discuss whether appellant's diagnoses or disability was related to the employment injury. His report, therefore, has little probative value in this case.

The Office referred appellant to Dr. Harry F. Jones, a Board-certified orthopedic surgeon, together with a statement of accepted facts and the case record, to resolve the conflict in the medical evidence. In a May 6, 1997 report, Dr. Jones diagnosed post laminectomy syndrome and aggravation of the condition by the October 15, 1990 employment injury. He indicated that appellant had a failed lumbar laminectomy and was limited to no lifting, no bending, no prolonged standing and no twisting. In a June 9, 1997 letter, the Office requested clarification on how the employment injury aggravated appellant's preexisting condition and whether the aggravation was temporary or permanent. Dr. Jones did not reply to the Office's letter.

The Office referred appellant, together with a statement of accepted facts and the case record, to Dr. Michael J. Smigielski, a Board-certified orthopedic surgeon, for an examination to resolve the conflict in the medical evidence. In a November 24, 1997 report, Dr. Smigielski stated that appellant was tender to palpation around the lumbar spine with minimal spasm. He found no atrophy in the quadriceps or gastrocnemius muscles. Dr. Smigielski reviewed the March 1996 CT scan and the April 1995 MRI scan and noted the prior L5-S1 laminectomy defect and disc bulges and degenerative changes from L4 to S1. He indicated that he did not see evidence of significant nerve root compression by recurrent discs. Dr. Smigielski diagnosed chronic low back pain. He stated that appellant's degenerative arthritis in the lumbar spine, which preexisted the employment injury and was secondary to the lumbar laminectomy. Dr. Smigielski stated that the soft tissue injury of the lumbar spine, sustained in the October 15, 1990 employment injury, had resolved without residuals. He indicated appellant had normal degenerative changes following surgery and aging. Dr. Smigielski stated appellant was capable of the light-duty work offered by the employing establishment. He reported appellant could drive 20 to 30 minutes, take a 5 to 10 minute break and then drive another 20 to 30 minutes.

In an April 20, 1998 report, Dr. Jones stated that appellant had neck pain secondary to the cervical spondylosis, which was aggravated by the employment injury and a preexisting

herniated L5-S1 disc, which was also aggravated by the employment injury. He indicated that appellant had permanent aggravations of his preexisting conditions involving the lower back and neck due to the employment injury. Dr. Jones concluded appellant was only capable of light sedentary work and was unable to drive except for short trips.

Dr. Jones was initially chosen to act as the impartial medical specialist in this case but did not provide any clarification of his initial report. When the Office secures an opinion from an impartial specialist and the opinion of the specialist requires clarification or elaboration, the Office has the responsibility to secure a supplemental report from the specialist for the purpose of correcting the defect in the original report. However, when the impartial specialist's statement of clarification or elaboration is not forthcoming or if the physician is unable to clarify or elaborate on his original report or if the supplemental report is also vague, speculative or lacks rationale, the Office must refer appellant to a second impartial specialist for a rationalized medical report on the issue in question.[2] The Office, therefore, properly referred appellant to Dr. Smigielski as Dr. Jones did not provide a timely response to the Office's request for clarification. Even if Dr. Jones were to be considered an impartial medical specialist, his report would be insufficient to resolve the conflict in the medical evidence because he gave no rationale for his opinion that appellant's employment injury had caused a permanent aggravation of the lumbar condition. His report, therefore, has little probative value.

Dr. Smigielski concluded that appellant's condition was due solely to the effects of the preexisting lumbar condition, particularly the lumbar laminectomy. He stated that the degenerative arthritis of appellant's back was the normal effects of the lumbar surgery and aging. Dr. Smigielski concluded on that basis that appellant's accepted lumbar strain had resolved. In situations when there exists opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[3] His report was based on an accurate history of appellant's case and was sufficiently, well rationalized to be given special weight. In the circumstances of this case, Dr. Smigielski's report constitutes the weight of the medical evidence and provides a sufficient basis for the Office's decision to terminate appellant's compensation.

[2] *Harold Travis*, 30 ECAB 1071 (1979).

[3] *James P. Roberts*, 31 ECAB 1010 (1980).

The decision of the Office of Workers' Compensation Programs dated April 26, 1999 and finalized on April 28, 1999 is hereby affirmed.

Dated, Washington, DC
June 1, 2001

David S. Gerson
Member

Bradley T. Knott
Alternate Member

A. Peter Kanjorski
Alternate Member