U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of BERNADETTA R. BROSKA and DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Philadelphia, PA

Docket No. 01-2107; Submitted on the Record;
Issued August 22, 2002

DECISION and ORDER

Before ALEC J. KOROMILAS, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether the Office of Workers' Compensation Programs met its burden of proof in terminating appellant's compensation benefits effective January 5, 1999 on the grounds that her work-related disability had ceased.

On September 2, 1998 appellant, then a 52-year-old tax examiner, sustained an injury to her left arm when she slipped and fell in the performance of duty. She stopped work on September 4, 1998.

In a September 10, 1998 report, Dr. Vincent Baldino, an osteopath and appellant's treating physician, noted that appellant's initial visit was on September 4, 1998. He indicated that appellant was seen at that time as she had fallen at work, striking her left forearm on a step. Appellant indicated that appellant presented today for swelling of the left arm which was red and very painful. He diagnosed cellulitis of the left upper extremity.[1] Appellant enclosed additional treatment notes from Dr. Baldino.

The Office accepted appellant's claim for cellulitis of the left arm.

In a September 28, 1998 report, Dr. Baldino indicated that appellant was totally disabled due to cellulitis of the left upper extremity.

Appellant provided electromyogram (EMG) studies performed October 13, 1998 which were interpreted as showing abnormal findings consistent with left carpal tunnel syndrome. She also provided EMG studies performed on December 1, 1998 which were interpreted as showing findings consistent with carpal tunnel syndrome, with "no evidence for denervation in any of the median innervated muscles above or below the wrist. There was also no evidence of radiculopathy or plexopathy."

[1] Appellant was admitted to the hospital.

In a report dated October 23, 1998, Dr. Stuart Trager, an orthopedic surgeon, evaluated appellant for complaints of numbness and tingling of the fingers. Dr. Trager's impression was carpal tunnel syndrome and de Quervain's tenosynovitis. In a November 6, 1998 report, he repeated his findings of left carpal tunnel syndrome as well as a component of de Quervain's tenosynovitis. In a December 4, 1998 report, Dr. Trager noted evidence of mild carpal tunnel syndrome. In a report dated December 16, 1998, he stated that he was concerned that the claimant's symptoms did not in fact necessarily reflect carpal tunnel syndrome. Dr. Trager stated that "Although she has had a negative MRI [magnetic resonance imaging] scan with regard to her cervical spine, I believe it is reasonable to check an MRI scan of her neck to rule out a herniated disc in this reason."

In a report dated January 4, 1999, Dr. Leonard Bruno, a Board-certified neurosurgeon, noted that he saw appellant on December 29, 1998 for complaints of neck pain radiating through the left upper extremity. Dr. Bruno referenced a December 22, 1998 MRl scan and concluded that appellant had cervical degenerative joint disease and a herniated disc at C6-7.

In a January 6, 1999 operative report, Dr. Bruno performed a C4-5, C5-6, C6-7 anterior cervical discectomy, graft arthrodesis and plate fixation.

In a report dated January 12, 1999, Dr. Baldino stated that on December 10, 1998 appellant complained of back, neck and shoulder pain and that an MRI scan revealed a cervical disc herniation and bulging discs with radiculopathy. He indicated that she underwent a laminectomy on January 6, 1999 and opined that the cervical disc herniation was a direct result of the September 2, 1998 fall.

By letters dated January 22, 1999, the Office wrote Drs. Bruno and Baldino for their opinions with reasons, as to whether the September 2, 1998 injury caused appellant's additional conditions.

On January 28, 1999 Dr. Baldino indicated that the cellulitis condition had resolved.

In a report dated February 1, 1999, Dr. Baldino opined that the carpal tunnel syndrome as well as the cellulitis and disc herniation were a direct result of appellant's fall on September 2, 1998.

By letter dated March 24, 1999, the Office referred appellant along with a statement of accepted facts and a copy of the case record to Dr. Steven Valentino, an osteopath and Board-certified orthopedic surgeon, for a second opinion evaluation.

In an April 7, 1999 report, Dr. Valentino stated that he had examined appellant and noted her history of injury and treatment. He stated that appellant's MRI scan of December 22, 1998, the films of which he reviewed as well as the reports, revealed foraminal stenosis at C6-7 secondary to chronic degenerative spondylolisthesis with minimal spurs at C4-5 and C5-6 but a large spur at C6-7 with chronic chord compression but no acute findings. Dr. Valentino noted that two EMG's showed normal cervical root function and no radiculopathy. He opined that the September 2, 1998 injury did not cause appellant's cellulitis, but was related to her diabetes, and that the injury did not cause an aggravation of appellant's cervical spondylolisthesis or herniated disc. Dr. Valentino stated that, while appellant's work incident could not be held accountable for

her complaints and treatment, she was disabled from significant gainful employment on the basis of cellulitis and aggressive surgical spine surgery. He indicated her nonindustrial disability was ongoing.

In a report dated May 26, 1999, Dr. Bruno indicated that when he originally saw appellant, the MRI scan revealed a bulge at C4-5 and a herniated disc at C6-7. He stated that he performed surgery on January 6, 1999. When he inspected the disc space, appellant had a huge herniated disc at C6-7 and he performed a C4-5, C5-6, C6-7 anterior cervical discectomy, allograft arthrodesis and plate fixation. Dr. Bruno opined that appellant's injury and resultant surgery were unequivocally work related.

By letter dated June 18, 1999, the Office advised appellant that she was being referred to Dr. Roy Lefkoe, a Board-certified orthopedic surgeon to resolve a conflict in the medical evidence as to whether the claimant sustained a cervical disc herniation or carpal tunnel syndrome as a result of the September 2, 1998 injury.

In a report dated July 6, 1999, Dr. Lefkoe noted appellant' s history of injury and treatment, noting that she had diabetes. He indicated that initial medical records showed that appellant missed a step and struck her left arm on September 2, 1998. Although there was no evidence that the skin was actually broken, an infection was introduced from the outside and appellant developed swelling, erythema and a cellulitis. Dr. Lefkoe noted that Dr. Baldino and his physical therapist made no mention of a neck injury or neck complaints initially. He also noted that Dr. Trager indicated that appellant's cellulitis was resolved and that she had carpal tunnel syndrome and a de Quervain's syndrome. Dr. Trager observed two sets of electrodiagnostic studies that showed only a carpal tunnel syndrome with no evidence of cervical radiculopathy. He opined that there was no evidence to indicate that the carpal tunnel syndrome was caused by the injury of September 1998 and that this was an extremely common finding in diabetics. Dr. Lefkoe stated that appellant had a multilevel anterior cervical discectomy and fusion on January 6, 1999. He explained that when Dr. Bruno was asked to address the issue of causation, he stated that appellant had neck pain from the outset and that she had a cervical herniation due to the hyperextension from the injury. However, Dr. Lefkoe opined that this conclusion was not supported by any of the facts that he reviewed. He noted that when Dr. Baldino was asked to address the issue of causation he felt that the cellulitis, carpal tunnel syndrome and cervical disc herniation were all a direct result of the September 2, 1998 incident, but he did not offer a rationalized opinion for his conclusion. Dr. Lefkoe stated that there was no evidence to indicate that appellant's cervical spondylolisthesis and large spur were either caused or aggravated by the injury of September 2, 1998. Further, he noted that Dr. Bruno performed the surgery as described and was planning elective removal of the hardware on July 29, 1999, however, he opined that the necessity for this second neck surgery was not work related. He indicated that appellant remained disabled, but following plate and screw removal, within several weeks, should be able to return to work at her usual occupation as a tax examiner for the Internal Revenue Service, without restriction.

In a report dated July 13, 1999, Dr. Bruno indicated that when he first saw appellant in his office on December 29, 1998, she gave a clear history of having had a severe fall at work on September 2, 1998, resulting in extension of her neck and causing her to develop immediate onset of severe and persistent neck pain and because of extending her left hand to protect herself

from further injury, she sustained an injury to her wrist and hand which resulted in persistent left wrist and hand pain as well. Dr. Bruno indicated that appellant had symptoms which were continuous from the date of injury onward, worsening over time and when he saw her on December 29, 1998, she was in acute distress. He stated that appellant had a severe left-sided C7 radiculopathy and an MRI scan from December 22, 1998, showed degenerative cervical disc disease at three levels, C4-5, C5-6 and C6-7, but in addition a very large disc herniation at the C6-7 level central and left sided. Dr. Bruno opined that the degree of hydration of the herniated portion of the disc, indicated that it was not of long-standing, that is less than six months old and he suggested that appellant consider undergoing surgery urgently for relief of her neurologic compromise. Dr. Bruno stated that appellant underwent anterior cervical discectomy and fusion on January 6, 1999 and at surgery was found to have an extruded fragment of disc at the C6-7 level causing spinal cord and nerve root compression of a severe degree. He opined that because of her cervical degenerative disc disease at the C4-5 and C5-6 levels, these had to be decompressed and fused as well to prevent further deterioration and compromise as a result of fusion at the C6-7 level. Dr. Bruno stated that it was his opinion within a reasonable degree of medical certainty that appellant's condition was unequivocally the result of a fall at work causing neck extension and acute disc herniation at the C6-7 level. He further opined that appellant had ongoing symptoms of carpal tunnel syndrome in the left hand as a result of falling onto her extended left wrist at the time of injury, September 2, 1998, in order to protect herself from further facial injury.

On October 4, 1999 the Office issued a proposed notice of termination of compensation. The Office advised appellant that her compensation for wage-loss and medical benefits were being terminated because she no longer had any continuing injury-related disability. Appellant was given 30 days to submit additional evidence or argument.

In a September 20, 1999 report, received by the Office on October 13, 1999, Dr. Bruno indicated that when he saw appellant on December 29, 1998, she gave him a clear and unequivocal history that on September 2, 1998 while climbing stairs at work, she fell face down, with her left arm extended in front of her to protect her face. He noted that appellant stated to him at that time that she did have an exaggerated neck extension type of injury when she turned her face and extended her neck in order to avoid facial trauma from falling and in fact did not suffer facial trauma because she was successful in avoiding this by the movement of her head and neck. Dr. Bruno indicated that she also used her left hand and arm to protect her face from trauma and this resulted in an arm injury, for which she was subsequently admitted to the hospital with redness, swelling and contusion of the arm diagnosed initially as cellulitis from the result of trauma suffered with the fall. He also indicated that appellant "stated unequivocally that the day following her fall on the steps, she experienced left arm pain that had been unremitting from the time of the accident onward," until the time he saw her in December 1998. Dr. Bruno also stated that appellant was also unequivocal that her pain had progressively worsened over time and that three months of physical therapy had given her no lasting benefit in the interim. He indicated that appellant's left arm and hand injury was responsible for all of her constellation of symptoms from that date forward resulting in neck spasm and pain, left arm pain, weakness and numbness and what turned out both by diagnostic testing and at surgery to be an acute disc herniation were clearly the result of injury she sustained at work as a result of her fall. Dr. Bruno opined that appellant was making a satisfactory recovery from her cervical fusion, had her fixation device removed, was undergoing active physical therapy and would benefit greatly from

carpal tunnel release on the left side. He stated that it was his opinion, that appellant's C6-7 disc herniation which was plainly verified at surgery as well as her left carpal tunnel syndrome were the direct result of injury sustained on September 2, 1998 at work.

In a November 3, 1999 report, Dr. Bruno opined that appellant sustained "a huge, acute herniated nucleus pulposus at C6-7 with a fragment on the spinal cord."

In a November 20, 1999 MRI scan, Dr. E. Michael Harned, a Board-certified radiologist determined that postoperative changes from C4 through C7, were new since December 19, 1998 with interval improvement of spondylitic changes, no other significant interval changes and no evidence of a herniated nucleus pulposus.

In an April 26, 2000 report, Dr. Bruno indicated the EMG/nerve conduction studies performed on October 13, 1998 were reasonable and necessary. He stated the study was performed because of appellant 's complaints of numbness in her left hand. Dr. Bruno stated that appellant's symptoms arose from and were directly related to her work injury of September 2, 1998, when she fell and extended her left arm to protect her fall.

By decision dated July 13, 2000, the Office finalized it proposed termination of benefits effective January 5, 1999.

By letter dated July 17, 2000, appellant's representative requested a hearing, which was held on January 23, 2001.

By decision dated May 17, 2001, the hearing representative affirmed the July 13, 2000 decision, finding that appellant no longer had any residuals of her September 2, 1998 injury.

The Board finds that the Office met its burden of proof in terminating appellant's compensation benefits effective January 5, 1999 on the grounds that her work-related disability had ceased by that date.

Once the Office accepts a claim, it has the burden of proving that the disability has ceased or lessened in order to justify termination or modification of compensation benefits.[2] 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.[3] The Office' s burden includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[4]

After termination or modification of compensation benefits, clearly warranted on the basis of the evidence, the burden for reinstating compensation shifts to appellant. In order to prevail, appellant must establish by the weight of the reliable, probative and substantial evidence

[2] *Lawrence D. Price,* 47 ECAB 120 (1995).

[3] *Id; see Patricia A. Keller,* 45 ECAB 278 (1993).

[4] *Raymond W. Behrens,* 50 ECAB 221 (1999).

that she had an employment-related disability, which continued after termination of compensation benefits.[5]

In this case, the Office accepted that appellant sustained cellulitis of the left arm and paid appropriate benefits.

Appellant's physician, Dr. Baldino reported that appellant had continuing total disability, while Dr. Valentino, the physician to whom appellant was referred for a second opinion, indicated that appellant's condition of cellulites was related to her diabetes and that the injury did not cause any aggravation of the claimant's cervical spondylolisthesis or herniated disc. Based on this conflict in medical opinion, as to whether appellant continued to have residuals of her accepted employment injuries and remained disabled for work, the Office referred appellant to Dr. Lefkoe, for an impartial examination.[6]

The Board finds that at the time the Office terminated medical benefits, the weight of the medical evidence rested with Dr. Lefkoe who submitted a thorough rationalized medical opinion based upon a complete and accurate factual and medical history. He performed a complete examination, reviewed the record, noted her condition of diabetes and advised that appellant had no continued disability from her accepted employment injury and that further medical treatment for the accepted employment injury was unnecessary. Dr. Lefkoe determined that initial medical records showed that appellant missed a step and struck her left arm and that no mention was made of a neck condition or carpal tunnel. He noted that once her cellulitis had resolved appellant was diagnosed with carpal tunnel and de Quervain's syndrome but no explanation was provided as to how this occurred. Dr. Lefkoe further explained that there was no evidence to suggest that the fall caused the carpal tunnel syndrome and explained that this was extremely common in diabetics. Upon review of the electrodiagnostic studies, he explained that they showed only a carpal tunnel syndrome with no evidence of cervical radiculopathy but nothing to indicate the carpal tunnel was caused by the fall. Dr. Lefkoe further noted that appellant had a multilevel anterior cervical discectomy and fusion on January 6, 1999, and the explanation as provided by Dr. Bruno which stated that appellant had neck pain as to the cause did not coincide with the facts and record as submitted. He also noted that Baldino stated that the cellulitis, carpal tunnel and cervical disc herniation were also caused by the September 2, 1998 incident but he did not explain why. Dr. Lefko opined that there was no evidence to suggest that appellant's cervical spondylolisthesis and large spur were either caused or aggarvated by the employment incident. He further noted that although appellant was disabled at this time, this was due to her second neck surgery which was nonwork related and following plate and screw removal, she should be able to return to her work as a tax preparer, without restriction.

When there exist 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 upon a proper factual

[5] *Talmadge Miller*, 47 ECAB 673, 679 (1996); *Wentworth M. Murray*, 7 ECAB 570, 572 (1955).

[6] 5 U.S.C. § 8123(a) of the Federal Employees' Compensation Act provides that when there is a disagreement between the physician making the examination for the United States and the physician of the employee, a third person shall be appointed to make an examination to resolve the conflict. *Henry P. Eanes*, 43 ECAB 510 (1992).

background, must be given special weight.[7] The Board finds that the report of Dr. Lefkoe represents the weight of medical opinion in this case and contains a well-rationalized opinion negating any continuing residuals due to the accepted employment injuries. As the weight of the medical opinion evidence, Dr. Lefkoe's report justifies the Office's termination of appellant's compensation benefits effective January 5, 1999. The burden of proof, thereafter, shifts to appellant.

Subsequent to the Office's proposed letter of termination, appellant submitted additional medical reports from her treating physicians.

In a July 13, 1999 report, Dr. Bruno stated that when he first saw appellant in his office on December 29, 1998, she gave a clear history that she developed the immediate onset of severe and persistent neck pain at the time of her fall. However, the initial medical reports merely state that appellant fell and struck her left forearm on a step. This is contradicted by all of the other documentation in the record. Medical evidence predicated on unsubstantiated diagnoses or inaccurate factual or medical history is of diminished probative value.[8] Dr. Bruno further opined that the disc herniation at C6-7 was clear and unequivocal, since it was observed at surgery. However, that in and of itself does not establish that it was caused by the September 2, 1998 injury instead of her preexisting three-level cervical degenerative disc disease. He stated further that, in his opinion, the degree of hydration of the herniated disc showed it was not long-standing. However, this does not establish that it was caused by the September 1998 work injury. In a September 20, 1999 report, Dr. Bruno repeated his description of the work incident as relayed in his July 13, 1999 report. Again the initial medical reports and appellant's initial statement do not support this description.[9] In a November 3, 1999 report, Dr. Bruno indicated that appellant had a "huge, acute, herniated nucleus pulposus at C6-7 with a fragment on the spinal cord." But he offered no explanation on causal relationship. In order to establish causal relationship, a physician's report must present rationalized medical opinion evidence, based on a complete factual and medical background.[10] In an April 26, 2000 report, Dr. Bruno opined that appellant's symptoms arose from and were directly related to her September 2, 1998 work injury when she fell and extended her left arm to protect herself. In this report, this description again is not supported by the initial reports of record and he had submitted no rationale for his opinion. Rationalized medical evidence is evidence, which relates a work incident or factors of employment to a claimant's condition, with stated reasons of a physician.[11]

Additionally, Dr. Bruno was on one side of the conflict that Dr. Lefkoe was selected to resolve. The Board does not find anything in Dr. Bruno's reports which is sufficient to overcome the weight that must be assigned to the opinion of the impartial medical specialist.[12]

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[7] *Carl Epstein*, 38 ECAB 539 (1987); *James P. Roberts*, 31 ECAB 1010 (1980).

[8] *See Bille C. Rae*, 43 ECAB 192 (1991).

[9] *Id.*

[10] *See Kathryn Haggerty*, 45 ECAB 383 (1994).

[11] *See Gary L. Fowler*, 45 ECAB 365 (1994).

[12] *See Harrison Combs, Jr.*, 45 ECAB 716 (1994).

Appellant also provided a November 20, 1999 MRI scan, however, this report did not contain any discussion of causal relationship.[13]

Consequently, appellant has not established that her condition on and after January 5, 1999 was causally related to her accepted employment injury.[14]

The decision of the Office of Workers' Compensation Programs dated May 17, 2001 is hereby affirmed.

Dated, Washington, DC
August 22, 2002

Alec J. Koromilas
Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member

[13] *Id.*

[14] In her appeal, appellant provided additional medical reports; however, the Board cannot consider new evidence on appeal. Appellant can submit the new evidence to the Office and request reconsideration pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. § 10.606(b)(2) (1999); *see* 20 C.F.R. § 501.2(c).