U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of LORI J. SENNETT and DEPARTMENT OF VETERANS AFFAIRS VETERANS ADMINISTRATION MEDICAL CENTER Wilkes Barre, PA

Docket No. 03-583; Submitted on the Record;
Issued October 8, 2003

DECISION and ORDER

Before COLLEEN DUFFY KIKO, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issue is whether the Office of Workers' Compensation Programs met its burden of proof in terminating appellant's compensation benefits effective December 7, 2000.

On September 8, 1999 appellant, then a 36-year-old former nurse filed a traumatic injury claim alleging that on March 23, 1999 her back became tight, stiff and painful and her arm was tight and heavy when she tried to turn and lift a patient.[1] The Office accepted the claim for lumbar and thoracic strain.[2] Appellant did not stop work.[3]

Appellant subsequently filed CA-7 forms for the periods from May 18 to August 10, 1999 and May 9 through June 23, 2000.[4]

In a February 8, 2000 clinic note, Dr. Albert D. Janerich, Board-certified in physical medicine and rehabilitation, indicated that appellant came in for treatment of injuries sustained while working on December 29, 1988 and more recently on March 23, 1999. He indicated that appellant was complaining of right side parascapular discomfort with radiation down the right

[1] The record reflects that appellant had a prior accepted claim for an injury on December 29, 1988, adjudicated by the Office under file No. 030139196. She initially filed the claim as a recurrence and subsequently filed as a traumatic injury. The record also reflects that appellant had a preexisting condition of severe fibromyalgia and fibrositis syndrome associated with degenerative disc disease.

[2] The Office denied appellant's recurrence claim in a June 29, 1999 decision. The Office also denied the claim on October 28, 1999 as she did not establish fact of injury. By decision dated February 29, 2000, the Office vacated the October 28, 1999 decision and found that the claim should be accepted for thoracic and lumbar strain.

[3] The record reflects that appellant last worked on May 18, 1999, when she was fired from the employing establishment for disrespectful conduct, failure to follow instructions and unauthorized absence. Appellant subsequently received Social Security benefits from May 18, 1999 for her nonwork-related degenerative disc disease, myofascial pain and a brachioplexus injury.

[4] Appellant filed on June 21, 2000; however, the employing establishment did not complete the forms.

arm and hand with numbness and tingling. Dr. Janerich indicated that appellant was lifting a patient when she injured her back and developed problems in the right arm, which were new since that injury, specifically complaints of right thoracic spine discomfort, right scapular pain with radiation down into the right arm. His impression was that the etiology of appellant's back pain and right arm discomfort stemmed from injuries sustained while working on December 29, 1988, which resulted in musculoligamentous strain to the cervicothoracic spine with a herniated thoracic disc at T8-9. Dr. Janerich stated that this had incompletely improved and, on March 23, 1999 appellant aggravated the preexisting injury as well as developed a right-sided brachial plexopathy.

In an April 20, 1999 report, Dr. Susan T. Depoliti Yang, a physician of unknown specialty, indicated that appellant had a history of chronic pain as it related to an old injury. She reviewed a magnetic resonance image (MRI) scan dated March 26, 1999, which revealed a herniated disc at the level of T7-8 centrally and to the left and moderate central bulging of the disc at the level of L4-5.[5] Her impression was myofascial trigger point syndrome, musculoligamentous injury to the thoracic and lumbosacral spine, discogenic disease secondary to thoracic and lumbar disc herniation, bilateral sacroiliac joint synovitis, bilateral trochanteric bursitis and bilateral supraspinatus tendinitis.

In a disability certificate dated March 20, 2000, Dr. Janerich indicated that appellant was unable to return to duty until further notice due to work-related injuries of March 23, 1999, which resulted in injury to the cervical spine and right upper extremity with aggravation of a previous work injury of December 29, 1988 to the thoracic spine. He noted that appellant was currently being treated for right brachial plexopathy, musculoligamentous injury, cervical and thoracic spine and discogenic disease. Further, he stated that appellant developed myofascitis involving the rhomboids and erector spinalis in the thoracic area on the right. In an April 11, 2000 disability certificate, he again advised that appellant was unable to work.

In an August 1, 2000 disability certificate, Dr. Janerich again reported that appellant was not to work until he saw her again.

In an August 14, 2000 treatment note, Dr. Janerich indicated that appellant remained in chronic pain, incompletely improved to, at best, 60 percent of normal. He noted that she remained with cervical and interscapular discomfort and sensory changes involving her right arm and her MRI scan showed evidence consistent with discogenic disease, especially in the thoracic spine area at T7-8. Dr. Janerich opined that appellant's condition was chronic and remained incompletely improved with nonoperative management as the likelihood of her benefiting from surgery was remote.

In clinic notes dated January 24, 2000, Dr. Janerich discussed appellant's fibromyalgia and recommended continued use of Skelaxin.

In his April 27, 2000 report, Dr. Janerich explained that he had been involved in appellant's care since January 11, 1993. He explained that he had treated her for her

[5] Dr. Yang compared this to a prior MRI scan performed on September 24, 1990.

December 29, 1988 work injuries, which included a musculoligamentous strain to the cervicothoracic and thoracolumbar spine. Dr. Janerich noted that an MRI scan of the lumbar spine conducted around that time disclosed evidence in keeping with degenerative disc disease at L4-5 without any frank herniation and explained that appellant improved such that she was able to return to full duty, even though she was not completely symptom-free but only 60 percent of normal. He indicated that on March 23, 1999 appellant injured her back and right arm while functioning in the capacity of a nurse. Dr. Janerich reviewed the MRI scans of the thoracic spine that were done in 1992 with abnormalities at T7-8 and T8-9, explaining that the changes at T8-9 were right sided and did not represent a frank herniation. Further, he noted that the March 26, 1999 MRI scan after the second accident, demonstrated a herniated disc with left-sided orientation at the level of T7-8. Dr. Janerich also indicated that, since the second accident, appellant was treated nonoperatively, as she was not a surgical candidate, with physical therapy and chiropractic care. He added that, when he examined appellant on February 8, 2000, she had limited range of motion about the cervical spine in extension, although flexion and rotation were normal. Dr. Janerich found right paravertebral and parascapular spasm, with two myofascial trigger points palpable, one in the erector spinalis, in the thoracic spine and one involving the rhomboids, with no scapular winging. He indicated that pain and guarding precluded an accurate assessment of the neurologic examination, although appellant did have sensory hypoesthesia to touch in the distribution of the C8-T1 nerve roots. Dr. Janerich opined that the cause of her cervicothoracic and right arm discomfort stemmed from injuries sustained on December 29, 1988 resulting in a musculoligamentous strain to the cervicothoracic spine. He explained that appellant's symptoms incompletely improved and on March 23, 1999 she aggravated the preexisting injury as well as sustaining a herniated disc at T8-9. Further, she developed at least a right-sided brachial plexus. Dr. Janerich summarized that appellant sustained an injury in 1988, which was a musculoligamentous strain with superimposed myofascitis, which had convalesced to about 60 percent of normal prior to the second injury on March 23, 1999. Dr. Janerich opined that the second injury resulted in a right-sided brachial plexus, a herniated thoracic disc and a recurrent musculoligamentous strain to the cervicothoracic spine with superimposed myofascitis. He determined that appellant was completely disabled from any form of laborious work that would involve the use of her right upper extremities.

By letter dated July 10, 2000, the Office requested that appellant submit additional information regarding the requested periods of disability.

On July 11, 2000 the Office referred appellant along with a statement of accepted facts, a set of questions and a copy of the case record to Dr. Sanford Sternleib, a Board-certified orthopedic surgeon, for a second opinion evaluation as to the nature and extent of appellant's work-related disability.

In an August 15, 2000 report, Dr. Sternleib, stated that he had examined appellant and noted her history of injury and treatment. He indicated that his evaluation was basically a normal examination. Dr. Sternleib reviewed the numerous MRI scans and advised that the MRI scan of the thoracic spine, which stated that there was a herniated disc in the thoracic region could only be regarded as a false positive reading with mild degenerative changes in the spine which were a normal part of the aging process. He opined that appellant did not have any hyperflexia in the lower extremities or any clonus, which would be present if she had any

significant anterior pressure on the spinal cord at that level. Dr. Sternleib explained that appellant did not continue to suffer residuals of the injury as she had an entirely normal examination. He noted that she may have incurred a sprain or strain of the soft tissues of the back at the time of the episode in 1999, but this would be a short-lived problem from which, there was no residual. Dr. Sternleib indicated that appellant had been treated for fibromyalgia and fibrositis, diagnoses which were highly subjective and without any objective supporting findings, advising that they were definitely related to her emotional status. He also indicated that her physical limitations were based upon her self-image and the major problems that she had were with stress. In an attached work capacity evaluation, Dr. Sternleib advised that there was nothing objective related to appellant's work injury of March 1999, which would suggest that she had any functional incapacity.

On October 24, 2000 the Office issued a proposed notice of termination of compensation. The Office advised appellant that her compensation for wage-loss and medical benefits was being terminated because she no longer had any continuing injury-related disabilities. The Office indicated that the weight of the medical evidence was demonstrated by the opinion of Dr. Sternleib, who advised that her work injury had resolved. Appellant was given 30 days to submit additional evidence or argument.

By decision dated December 7, 2000, the Office finalized its proposed termination of benefits. The Office indicated that Dr. Sternleib's opinion remained the weight of the medical evidence.

Appellant requested reconsideration on December 20, 2000 and submitted an April 27, 2000 report from Dr. Janerich, which had been previously received by the Office.

By decision dated February 2, 2001, the Office denied appellant's reconsideration request on the grounds that the evidence submitted was repetitious and, therefore, insufficient to warrant review of its prior decision.

Appellant continued to submit medical evidence and in a February 6, 2001 report, Dr. Janerich opined that appellant was precluded from any type of gainful laborious work, especially work that employed her right arm. He indicated that this was a result of the work-related injuries.

On March 12, 2001 appellant again submitted CA-7 forms for the periods May 18 to August 10, 1999 and May 9 through June 23, 2000.

In a March 19, 2001 attending physician's report, Dr. Janerich again indicated that appellant had a herniated thoracic disc and right brachial plexopathy. He opined that appellant was unable to return to work.

In a March 16, 2001 attending physician's report, Dr. Raphael J. Bonita, Board-certified in internal medicine, opined that appellant had a herniated disc at T8-9 and fibrositis/fibromyalgia syndrome.

In an April 23, 2001 report, Dr. Janerich reiterated his opinion that appellant was completely disabled from any form of laborious work that would involve the use of her right upper extremity.

In a May 15, 2001 MRI scan, Dr. Bollaiah Borra, a Board-certified diagnostic radiologist, indicated that T1 sagittal images showed normal signal intensity in the thoracic vertebral bodies and alignment appeared normal. He also noted that the spinal cord appeared normal. Dr. Borra found minimal narrowing of the disc space seen at T7-8 and T8-9. He observed that the T2 weighted sagittal images showed loss of signal in the discs at T7-8 and T8-9 and no increased signal intensities were seen in the spinal cord. Dr. Borra found very minimal anterior extradural compression at T7-8 level and TI and T2 axial images obtained in the mid thoracic level and vertebral bodies and prevertebral soft tissues. He also noted minimal anterior extradural compression over the thecal sac and spinal cord on the left side at what appeared to be at T7-8. Dr. Borra found no evidence of spinal stenosis at this level and indicated no other abnormalities were seen. He added that the conus appeared normal.

By letter dated August 6, 2001, appellant requested reconsideration. In support of her request, she enclosed a July 11, 2001 report from Dr. Janerich.[6]

In his July 11, 2001 report, Dr. Janerich again opined that appellant sustained an injury on March 23, 1999 while working. He explained that, as a result of this injury, appellant now had right brachial plexopathy and the injury aggravated the T7-8 disc protrusion that she sustained on December 29, 1988. Dr. Janerich indicated that appellant experienced constant back and right arm pain and opined that she never fully recovered and has thus, been unable to work from May 18, 1999 to the present due to her work-related injuries of March 23, 1999, which aggravated the injury of December 29, 1988. Further, he included a copy of the May 15, 2001 MRI scan, showing a protruding disc at T7-8, which he believed supported appellant's multiple subjective complaints.

In an August 21, 2001 report, Dr. Janerich again diagnosed myofascitis and right-sided brachial plexitis/brachial plexopathy. He noted that appellant was experiencing a flare involving the parascapular area on the right side and her lumbar area.

Appellant also provided physical therapy notes from August 27 to November 7, 2001.

By letter dated October 23, 2001, the Office advised appellant that it determined a conflict existed and referred her to Dr. George Ritz, a Board-certified orthopedic surgeon.

In his November 16, 2001 report, Dr. Ritz noted appellant's prior history of injury and treatment and stated that it was his opinion that appellant suffered a thoracic strain as a result of the March 23, 1999 work injury. He indicated that the treatment appellant received from Dr. Bonita was in reference to her fibromyalgia and not her work-related thoracic sprain. Dr. Ritz added that appellant's complaints of numbness on physical examination did not

[6] It also appears from the record that on August 8, 2001 the Office received the history related to appellant's previous claim, along with duplicate records.

correlate with any specific peripheral nerve or dematomal area on the upper extremity and did not correlate with her electromyography study, which found no evidence of a brachial plexus injury, a cervical radiculopathy or medial ulnar neuropathy. He opined that the thoracic strain was connected to the work injury by direct cause and expected this to be a temporary condition which resolved over time. Dr. Ritz opined that appellant was not disabled as a result of any work injury which occurred on March 23, 1999. He noted that she was able to continue working for approximately six weeks and it was his opinion that the complaints were not due to the related 1988 or 1993 work injuries. Finally, Dr. Ritz stated that it was his opinion that appellant's diagnosis of fibromyalgia was not work related, that there was not a period of total disability as a result of her work-related condition and that she was not in need of treatment for her back, based on the work injury from March 1999.

By decision dated January 23, 2002, the Office denied modification of the its prior decisions, as the evidence was insufficient to warrant modification.

The Board finds that the Office did not meet its burden of proof in terminating appellant's compensation benefits effective December 7, 2000, 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.[7] 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.[8] The Office's burden includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[9]

In this case, the Office accepted that appellant sustained lumbar and thoracic strain.

The medical evidence relevant to the termination of appellant's compensation claim includes reports from her treating physician, Dr. Janerich, who diagnosed discogenic disease, musculoligamentous strain to the cervicothoracic spine with a herniated disc at T8-9 and right-sided brachial plexity. Further, he stated that appellant was disabled due to her employment injuries. In his August 14, 2000 treatment notes, Dr. Janerich indicated that appellant remained in chronic pain, was incompletely improved, reaching only 60 percent of her normal capacity, that the MRI scan showed evidence consistent with discogenic disease, especially in the thoracic spine area at T7-8 and opined that her condition was chronic. In his April 27, 2000 report, Dr. Janerich explained that, in relation to the second accident, changes at T7-8 included a herniated disc with left-sided orientation. He reported that appellant had continuing total disability.

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

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

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

Dr. Sternleib, the physician to whom appellant was referred for a second opinion, noted her history of injury and treatment and opined that appellant did not suffer residuals of her injury as she had an entirely normal examination. He stated that the MRI scan report of a herniated disc in the thoracic region could only be regarded as a false positive reading, as there were only mild degenerative changes in the spine, which were a normal part of the aging process. Dr. Sternleib opined that appellant did not have hyperreflexia in the lower extremities or clonus findings which would be present if she had any significant anterior pressure on the spinal cord at that level. He explained that she did not continue to suffer residuals of the injury as she had an entirely normal examination. Dr. Sternleib noted that appellant may have incurred a sprain or strain of the soft tissues of the back at the time of the episode in 1999, but this would be a short lived problem from which there was no residual at the time of his examination. He indicated that appellant had been treated for fibromyalgia and fibrositis, diagnoses which were highly subjective and without any objective supporting findings and were definitely related to her emotional status. Dr. Sternleib also indicated that her physical limitations were based upon her self-image and that the major problem appellant had was stress.

In the instant case, the Board finds a conflict in the medical evidence between appellant's treating physician, Dr. Janerich and that of the second opinion physician, Dr. Sternlieb. The reports of the physicians are in conflict as to whether she has any continuing disability relating to her accepted work injury. Appellant's treating physician Dr. Janerich, found that she remained disabled as a result of her work injury on March 23, 1999. Dr. Sternlieb opined that appellant's accepted conditions had resolved, that she had a completely normal examination and noted that there was no objective evidence to support work-related disability.

Where 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.[10] Based on the above-referenced conflict in the medical evidence between Drs. Janerich and Sternlieb, the Board finds that the Office should have referred appellant's case for an impartial medical examination.[11] Accordingly, the decision dated January 23, 2002 is set aside and the case remanded for further consideration.

[10] 5 U.S.C. § 8123(a); *see also Lawrence C. Parr*, 48 ECAB 445, 453 (1997).

[11] *See Craig M. Crenshaw, Jr.*, 40 ECAB 919 (1989).

The January 23, 2002 decision of the Office of Workers' Compensation Programs is hereby reversed.

Dated, Washington, DC
October 8, 2003

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member