United States Department of Labor
Employees' Compensation Appeals Board

MANUEL A. OLIVER, Appellant	)	
and	)	**Docket No. 04-443**
	)	**Issued: June 8, 2004**
U.S. POSTAL SERVICE, POST OFFICE, San Juan, PR, Employer	)	

Appearances:
Capp Taylor, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member

JURISDICTION

On December 9, 2003 appellant filed a timely appeal from the Office of Workers' Compensation Programs' merit decision dated November 10, 2003, denying modification of a September 11, 2001 decision terminating appellant's compensation effective October 6, 2001. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over this case.

ISSUE

The issue is whether the Office met its burden of proof to terminate appellant's compensation effective October 6, 2001.

FACTUAL HISTORY

On October 14, 1976 appellant, then a 30-year-old clerk, filed a traumatic injury claim alleging that he injured his back while lifting a 50-pound can. The claim was accepted for lumbar strain, left lateral chest arm strain and later a herniated nucleus pulpous (HNP) at L5-S1. Appellant returned to light-duty work after a few weeks. He filed recurrence claims in 1977,

1980 and 1982, that were accepted. In 1989 appellant resigned from the employing establishment and relocated to Florida where he worked light duty for a Navy Hospital until June 1993, when he was terminated for medical reasons. Appellant returned to the periodic rolls effective September 2, 1993 and has not worked since then. In 1993 appellant filed an emotional claim that was denied.

A January 14, 1999 report summarizing a postal investigation of appellant indicated that he was seen going up and down four flights of stairs carrying a small child in one arm. Appellant was also observed bending and squatting as he pulled weeds from a garden, picking up a suitcase and carrying a screen door on his shoulder and loading it into a van.

In a March 23, 2000 letter, the Office referred appellant for a second opinion. In an April 10, 2000 report, Dr. Donald Pearson, an orthopedic surgeon and the Office referral physician, wrote that appellant presented with complaints of low back pain, numbness in his left leg, aching hands, arthritis, dizziness, panic attacks and high blood pressure. On examination he found no asymmetry, muscle atrophy, motor weakness or trigger points in appellant's lower back and full forward flexion to 90 degrees with no muscle spasms. Dr. Pearson noted that appellant moved well on and off the table and had a good range of motion in his hips. After reviewing appellant's medical history, including x-rays, the investigative film and report he diagnosed degenerative disc disease of the lumbosacral spine, chronic low back pain with HNP at L5-S1 and radiculopathy in the left leg. Dr. Pearson also opined that appellant had no residuals from his accepted work injuries and could perform his date-of-injury job. In a June 29, 2000 decision, the Office terminated appellant's compensation.

Appellant requested a hearing and submitted a June 8, 2000 report from Dr. Edward Feldman, a Board-certified orthopedic surgeon, who stated that appellant presented with pain in his lower back and had left arm pain and trembling in his left hand. On examination he found appellant with an antalgic gait, difficulty walking on his toes and heels and discomfort on flexion, extension and rotation. Dr. Feldman diagnosed herniated lumbar disc at L5-S1, degenerative disc disease secondary to the herniated disc, chronic L5 radiculopathy and depression secondary to chronic pain. He opined that appellant was totally disabled and that his symptoms are secondary to work-related injuries. On September 29, 2000 appellant completed a functional capacity evaluation (FCE) that showed he could perform in sedentary position but not in his date-of-injury job as a postal clerk because he could not meet the strength classifications of that position. The report further noted that appellant may be able to do some of the activities for short periods of time, but lacked the strength to perform them over a sustained period.

In a September 29, 2000 report, Dr. Chet Janecki, an orthopedic surgeon, stated that appellant presented with low back pain, pain in the left buttocks, pain and numbness in the lower left extremity with shooting pain into the left lower extremity and big toe. On physical examination he found a normal gait with slight favor of the left leg, tenderness to palpation at L4-5 and S1 joints and the buttocks on the left side. Straight leg raising was painful in the back and buttocks as was Fabere testing on the left. He noted strength as 5/5 in the L3-S1 distribution, with diminished sensation in the L4-5 and S1 distribution on the left. Dr. Janecki noted that x-rays of the lumbar spine showed severe degenerative disc disease at L5-S1 with osteophyte formation, both anterior and posterior and facet arthopathy at L5-S1 and L4-5 with sclerosis

noted around both S1 joints as well. He noted that there was interneural foramen narrowed at L5-S1. Dr. Janecki stated that appellant has a significant injury to his lumbar spine as a result of the accepted work injury and that he is totally disabled.

In a December 15, 2000 progress note, Dr. Victor Ogilvie, a clinical psychologist, stated that appellant was a service-related disabled veteran being treated for an adjustment disorder with mixed emotional features due to severe job stress secondary to an on-the-job injury. He noted that appellant's current symptoms were frustration, anxiety, depression and severe insomnia.

In a March 15, 2001 decision, the hearing representative vacated the Office termination and remanded the case for further development, noting a conflict in the medical evidence between Drs. Feldman and Pearson. In a March 27, 2001 letter, the Office referred appellant to Dr. Narinder Aujla, a Board certified orthopedic surgeon, for an independent medical examination.

In an April 16, 2001 report, Dr. Aujla stated that appellant presented with what he described as constant back pain 90 percent of the time and 10 percent of the time with pain that goes down his left leg. He noted that appellant was in no acute distress and had no spasms or scoliosis to palpation. There was no sciatic notch tenderness but there was tenderness to the lower lumbosacral area. Dr. Aujla stated that appellant could walk on his heels and toes, squat fully and stand up without a problem. Lumbar spine extension was about 30 degrees and flexion was 75 degrees with some lumbosacral discomfort. He noted that sitting down appellant could extend both knees without arching his back, that there was no motor weakness in the lower extremity muscle groups and that both hips and knees were pain free with full range of motion. Dr. Aujla stated that appellant's records and examination clearly show that appellant had no signs of a herniated disc or radiculopathy and that his symptoms are subjective without objective evidence to support them. He added that appellant's present symptoms are primarily related to lumbar disc degeneration, chronic inactivity, lack of physical conditioning and depression. He diagnosed chronic lumbar strain and lumbar disc degeneration of L5-S1 with facet hypertrophy and opined that, based on his examination and his review of the surveillance tape, appellant could perform moderate activities involving sitting, standing, walking and lifting restrictions of about 30 pounds. In a June 19, 2001 clarifying report, Dr. Aujla stated that appellant's work-related orthopedic injuries had resolved, that he had reached maximum medical improvement and that continuing symptoms are more related to nonwork-related factors than to the continuation of his work-related injuries.

In a July 30, 2001 letter, the Office proposed terminating appellant's compensation. In a September 11, 2001 decision, the Office finalized the termination effective October 6, 2001.

Appellant requested reconsideration and submitted a March 8, 2002 report from Dr. David Peterson, a Board-certified orthopedic surgeon, who wrote that he had reviewed appellant's medical and work history and, in his opinion appellant was disabled from full-time work due to his accepted work injuries. He based his opinion on the findings of numerous objective tests and clinical examinations. In a July 31, 2002 decision, the Office denied modification.

After numerous requests for a copy of the surveillance tape appellant received the tape. In a July 22, 2003 reconsideration request appellant submitted a July 9, 2003 report from Dr. Peterson, who stated that on physical examination he found intermittent left leg numbness three to four times a month that was severe for a day or two then tapered off. He noted tenderness in the left S1 joint area lumbrosacral junction. The neurological examination was nonfocal except for an occasional distracted straight leg raising at four degrees. Dr. Peterson stated that he had seen the surveillance tape, but it did not change his opinion that appellant's injuries are permanent and have existed since the original work injury in 1976. In a November 10, 2003 decision, the Office denied modification finding the weight of the medical evidence rested with Dr. Aujla, as the independent medical examiner.

LEGAL PRECEDENT

Under the Federal Employees' Compensation Act,[1] once the Office has accepted a claim it has the burden of justifying termination or modification of compensation benefits.[2] The Office may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.[3] The Office's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[4]

In situations where 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 background, must be given special weight.[5]

When the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, the Office must secure a supplemental report from the specialist to correct the defect in his original report.[6] However, when the impartial specialist is unable to clarify or elaborate on his original report or if his supplemental report is also vague, speculative or lacking in rationale, the Office must submit the case record and a detailed statement of accepted facts to a second impartial specialist for the purpose of obtaining his rationalized medical opinion on the issue.[7]

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[1] 5 U.S.C. § 8101 *et seq.*

[2] *Charles E. Minniss*, 40 ECAB 708, 716 (1989); *Vivien L. Minor*, 37 ECAB 541, 546 (1986).

[3] *Id.*

[4] *See Del K. Rykert*, 40 ECAB 284, 295-96 (1988).

[5] In situations where 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 background, must be given special weight. *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

[6] *April Ann Erickson*, 28 ECAB 336, 341-42 (1977).

[7] *Harold Travis*, 30 ECAB 1071, 1078 (1979).

ANALYSIS

In the present case, the Board finds the reports of Dr. Aujla do not merit the special weight accorded to a well-rationalized report from an independent medical examiner as they are ambiguous and unrationalized. In his April 16, 2001 report, Dr. Aujla stated that appellant had no evidence of a herniated disc. He did not provide any explanation for this finding which is contrary to the Statement of Accepted Facts and the preponderance of the medical evidence in the record. The Board has found that a medical opinion which is not based on a complete and accurate factual and medical history is of limited probative value.[8] Dr. Aujla did not provide an explanation of how appellant's accepted employment injuries -- lumbar strain, left lateral chest arm strain and a HNP at L5-S1 -- had resolved such that they no longer caused disability.

The Office recognized the inadequate nature of Dr. Aujla's first report and sought clarification. In his June 19, 2001 report, Dr. Aujla stated that in his opinion appellant's work-related injuries had resolved and his continuing symptoms are more related to nonwork related-factors than a continuation of his work-related injury. Once again Dr. Aujla failed to support his opinion with sufficient rationale as he does not explain the basis of that opinion. Moreover, his supplemental opinion is ambiguous. It says appellant's symptoms are more related (emphasis added) to nonwork factors than to work related ones; leaving open the possibility that he attributes some of appellant's symptoms to his accepted injuries.[9]

For the reasons described above, the Board finds the Office improperly gave special weight to the reports of Dr. Aujla, as the independent medical examiner.

CONCLUSION

The Office has not met its burden of proof to terminate appellant's compensation.

[8] *See William Nimitz, Jr.*, 30 ECAB 567, 570 (1979).

[9] It should be noted that Dr. Aujla reviewed a surveillance tape of appellant's activities and, although the record appears to contain a description of the tape's contents, the tape itself is not present in the record.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 10, 2003 is reversed.

Issued: June 8, 2004
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member