

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ROGER G. PAYNE and U.S. POSTAL SERVICE,
POST OFFICE, Chester, PA

*Docket No. 03-1719; Submitted on the Record;
Issued May 7, 2004*

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 to terminate payment for intravenous therapy for appellant's accepted respiratory condition.

On December 13, 1993 appellant, then a 43-year-old postmaster, filed an occupational disease claim alleging that he developed headaches, nausea, weakness, lower right side pain, chest pain, difficulty breathing, blurred vision, ringing in his head, memory loss and loss of hand-eye coordination, causally related to his exposure over a six-week period to an oil-based paint used at the employing establishment. The Office accepted that appellant sustained upper respiratory inflammation, asthma, aggravation of reactive airway disease and a somatization disorder, causally related to his exposure to paint fumes over six weeks.

In November 1993, appellant came under the treatment of Dr. Roy E. Kerry, a Board-certified otolaryngologist, who diagnosed multiple chemical sensitivities and prescribed a course of treatment, which included regular weekly infusions of intravenous vitamins and minerals to detoxify appellant's system and to strengthen his immune response. During his treatment, appellant was also seen by a variety of other physicians for respiratory and other problems.

The Office continued to develop the claim and referred appellant for a second opinion examination by Dr. Michael E. Wald, a Board-certified internist specializing in pulmonary diseases. On December 3, 1998 Dr. Wald noted appellant's complaints of shortness of breath and wheezing on exertion or exposure to fumes, that he used medication every morning and a rescue inhaler when necessary and that ventilation studies demonstrated moderate airways obstruction with a partial response to bronchodilation. Dr. Wald diagnosed appellant as having objective findings consistent with asthma causally related to his industrial exposure. The physician recommended aggressive treatment with a leukotriene inhibitor and chronic inhaled steroid preparation to block the asthmatic inflammatory reaction and work restrictions protecting

appellant's environment. He did not comment on the efficacy of intravenous (IV) vitamin therapy for appellant's condition.

Appellant continued receiving intravenous infusions of vitamins and minerals on a weekly basis.

On February 3, 1999 the Office referred the case record to an Office medical adviser, who replied on March 19, 1999 that appellant had not been accepted as having multiple chemical sensitivities. He stated that weekly intravenous vitamin therapy was not within mainstream medical practices and had no effect on and did not treat asthma, appellant's accepted condition.

On March 23, 1999 the Office advised appellant that it was rescinding its prior authorization for intravenous vitamins and minerals therapy. Appellant disagreed with this action and by letter dated April 22, 1999, he claimed that his treatments helped him to breathe better and afforded a better quality of life.

On May 17, 1999 the Office issued a notice of proposed termination of medical benefits, indicating that the weight of the medical evidence established that intravenous vitamin therapy was not necessary or beneficial for appellant's accepted asthma condition. The Office advised appellant that he had 30 days within which to provide evidence or argument to the contrary.

By letter dated June 16, 1999, appellant, through his representative, requested that the proposed termination of intravenous vitamin therapy be set aside. Appellant contended that the medical evidence of record which addressed intravenous vitamin therapy explained how he obtained relief from this therapy.

By decision dated June 17, 1999, the Office disallowed appellant's claim for intravenous vitamin therapy, finding that the treatment was not a mainstream medical practice. The Office noted that appellant remained entitled to compensation for temporary total disability. The Office reissued its decision on June 23, 1999, noting that the condition of multiple chemical sensitivities had not been accepted and that Dr. Kerry's intravenous vitamin therapy had no effect on the accepted asthma.

On June 23, 1999 the Office received a June 10, 1999 narrative report from Dr. Kerry, who stated that he was treating appellant's overall underlying problems and not just his respiratory symptomatology. Dr. Kerry noted that appellant needed a restricted environment, including air filtration systems and contended that the intravenous therapy appellant received treated his condition at the cellular level to reduce his bronchospasm. Dr. Kerry noted that, even though such intravenous treatment was not part of mainstream medicinal practice, that did not negate the benefit that had been shown in appellant's case. He contended that the therapy should be reimbursable as improvement in the patient resulted. Dr. Kerry recommended continuation of intravenous nutrient therapies since they were proving effective for symptom control.

Appellant objected to the disallowance of his intravenous vitamin therapy and requested an oral hearing before an Office hearing representative. In reviewing the case record, the hearing representative found that it was not in posture for decision. On December 3, 1999 the hearing representative remanded the case to the Office for further development, including a second opinion report specifically addressing the issue.

As Dr. Wald was not available, the Office referred appellant, together with a statement of accepted facts, questions to be addressed and the relevant case record, to Dr. Michael L. Steinberg, a Board-certified allergist and immunologist, for a second opinion evaluation.

In a report dated July 19, 2000, Dr. Steinberg reviewed appellant's factual and medical history, noted his present complaints and provided findings upon clinical examination. Dr. Steinberg opined that the diagnosis of reactive airways disease was somewhat supported by the pulmonary function testing results, but also that the findings were consistent with restrictive lung disease as well. He did not believe in the diagnosis of multiple chemical sensitivities and felt the major component of appellant's condition was psychophysiologic. Dr. Steinberg opined that the diagnosis of exacerbation of reactive airways disease fit chronologically with appellant's timeline and indicated that it would be improved by inhaled steroids and other modulators of airway inflammation. He advised that appellant's condition was permanent with ongoing exacerbations, from time to time based on exposures. With respect to multiple chemical sensitivities, Dr. Steinberg opined that improvement depended on treating the psychological component of the condition, as well as finding a competent physician that appellant could trust. Dr. Steinberg opined that continuation of the intravenous vitamin and mineral therapy was unnecessary and recommended that appellant was employable under the right circumstances but should not be exposed to significant levels of toxic and/or noxious vapors, fumes and odors.

The Office found a conflict in medical opinion evidence between Dr. Kerry and Dr. Steinberg as to the efficacy and necessity of the intravenous infusion vitamin therapy. The Office referred appellant, together with a statement of accepted facts, questions to be addressed and the case record, to Dr. Lawrence Caliguiri, a Board-certified allergist and immunologist, selected as the impartial medical specialist.

In a report dated February 21, 2001, Dr. Caliguiri reviewed appellant's factual and medical history including his accepted 13-day exposure in 1993 to paints and solvents. The physician listed appellant's present complaints, discussed the findings of pulmonary function testing and diagnosed asthma, chronic bronchitis, somatization disorder and gastroesophageal reflux by history. Dr. Caliguiri noted that appellant had a long-standing respiratory disorder, which was characterized as bronchitis but treated as reactive airway disease, which suggested preexisting asthma. He indicated that appellant had had a progressive decrease in his pulmonary function from 1994 to the present, which he attributed to inadequate treatment of the obstructive pulmonary disease. Dr. Caliguiri related appellant's recurrent bronchitis to his history of cigarette smoking and his passive exposure to smoke during his childhood and his second marriage from 1980 until 1992. He noted that there was no evidence for autoimmune activity as indicated by a negative rheumatoid, thyroid and antinuclear antibody testing. Dr. Caliguiri noted that, following albuterol aerosol in his office, appellant felt improvement in his breathing similar to that which he experienced after his intravenous infusion therapies. He noted that the detoxification infusion did contain magnesium, which had been used in the past to treat asthma. Dr. Caliguiri stated that the paint fumes at work aggravated appellant's asthma, which would have been temporary if treated aggressively, but which was not adequately treated in appellant's

case. He indicated that he did not feel that multiple chemical sensitivity was a valid diagnosis and was more accurately defined as a functional somatic syndrome. Dr. Caliguiri stated:

“I do not feel that intravenous therapy is indicated in [appellant]. It may be harmful for two reasons. First, by receiving weekly intravenous infusions, it is preventing [appellant] from receiving adequate and appropriate treatment for control of his persistent asthma and functional somatic disorder. Second, it increases the climate surrounding functional somatic disorders by mobilizing parties with a vested self-interest in these syndromes.”

Dr. Caliguiri opined that home and automobile filtration would not benefit appellant's indoor environment significantly. The only work limitations he noted were based on appellant's pulmonary and low back disorders. Dr. Caliguiri indicated that appellant should work in an air conditioned environment free of noxious fumes, cigarette smoke and dust.

On February 11, 2002 the Office issued a notice of proposed termination of medical benefits on the need for continued intravenous vitamin therapy for appellant's occupational asthma condition. It found the report of Dr. Caliguiri constituted the weight of the medical opinion.

By report dated February 23, 2002, Dr. Kerry responded to the Office's letter of proposed termination of intravenous vitamin therapy, noting appellant's history of exposure over a six-week period. Dr. Kerry indicated that laboratory tests were done, which confirmed damage, which he felt was usually secondary to intense petro-chemical exposures such as the paint exposure appellant sustained. He noted that appellant had damaged T cells in the immune system, liver enzyme abnormalities and an elevated rheumatoid factor confirming the immunologic damage. Dr. Kerry initiated intravenous therapy to treat appellant's chronic bronchitis and asthma and noted that earlier 1994 therapy improved appellant's breathing and some other symptoms typical of the chemical damage affecting his memory and neurologic system. Dr. Kerry noted that, upon skin testing, appellant was reactive to formaldehyde, phenol and petroleum products and that further testing documented a sensitivity to xylene, a common paint solvent. Dr. Kerry discussed appellant's hepatic detoxification pathways, which included intravenous therapies and argued that intravenous therapy was based on scientific reasoning. Dr. Kerry referred to two attached articles by Drs. Majid Ali and W.A. Schrader, physicians of unclear specialties, as showing the reason and benefit of intravenous therapy. Dr. Kerry noted that Dr. Caliguiri stated that magnesium has been used to treat asthma and he indicated that the intravenous infusions contained magnesium. He also claimed that air filtration systems for both the car and home were absolutely necessary as a means to eliminate toxins.

By letter dated March 13, 2002, appellant, through his attorney, disagreed with the proposed action arguing that Dr. Caliguiri's report was not well rationalized.

On May 21, 2002 the Office again issued a notice of proposed termination of the intravenous vitamin therapy. The Office found that the report of Dr. Caliguiri constituted the weight of the medical opinion evidence as it resolved a conflict between Dr. Kerry and Dr. Steinberg on the issue of whether the intravenous vitamin infusions constituted appropriate treatment of appellant's employment-related asthma condition.

Appellant disagreed with the proposed action and he submitted a June 4, 2002 report from Dr. Kerry, who reiterated his disagreement with Dr. Caliguiri's medical opinion.

On July 22, 2002 the Office finalized the termination of intravenous therapy. The Office found that Dr. Caliguiri's medical opinion resolved the conflict on the issue of whether such therapy was necessary.

On July 30, 2002, appellant, through his attorney, requested an oral hearing before an Office hearing representative, that was subsequently changed to a request for a review of the written record. Appellant submitted medical progress notes from Dr. Kerry, which indicated that he continued to use a nebulizer and received intravenous infusions.

By decision dated June 9, 2003, the hearing representative affirmed the July 22, 2002 decision, finding that the recommendation of Dr. Caliguiri, the impartial medical specialist, established that intravenous vitamin therapy was not necessary for the treatment of appellant's accepted condition.

The Board finds that the Office met its burden of proof to terminate reimbursement for appellant's intravenous therapy.

In the present case, the Office accepted appellant's medical treatment by Dr. Kerry, which included weekly intravenous therapy of the accepted condition. The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability compensation.¹ To terminate authorization for medical treatment, the Office must show that such treatment is no longer warranted.²

Dr. Kerry recommended and instituted weekly intravenous vitamin therapy for treatment of appellant's employment-related upper respiratory inflammation, asthma, aggravation of reactive airway disease and a somatization disorder. The Office initially paid for such therapy. However, following review by an Office medical adviser, who determined from applicable medical literature that intravenous vitamin therapy was not within mainstream medical practices, it was recommended that such therapy be discontinued. Upon further development, a second opinion physician, Dr. Steinberg, examined appellant and also opined that continuation of intravenous vitamin therapy was unnecessary.

The Act, at 5 U.S.C. § 8123, states that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination. In accordance with 5 U.S.C. § 8123, the Office found that a conflict arose between the medical opinions of Dr. Kerry and Dr. Steinberg and referred appellant for an impartial medical examination. The Board notes that when a case is referred to an impartial medical specialist for the purpose of resolving a conflict

¹ *Stella M. Bohlig*, 53 ECAB ____ (Docket No. 00-749, issued February 8, 2002).

² *See Franklin D. Haislah*, 52 ECAB 457 (2001); *Alfredo Rodriguez*, 47 ECAB 437 (1996).

in medical opinion, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual and medical background, must be given special weight.³

On February 21, 2001 Dr. Caliguiri, a Board-certified allergist and immunologist, examined appellant and opined that he did not feel that continuing intravenous therapy was indicated and he noted that it might be harmful for two reasons. Dr. Caliguiri stated that, by receiving weekly intravenous infusions, appellant was prevented from receiving adequate and appropriate treatment for control of his persistent asthma and functional somatic disorder and that such infusions increased the climate surrounding appellant's functional somatic disorder by mobilizing parties with a vested self-interest in such a syndrome. Dr. Caliguiri's opinion was based upon a proper factual and medical background and upon objective testing results. The Board finds that the physician's report is well rationalized, such that it is entitled to special weight. Dr. Caliguiri's medical opinion constituted the weight of the medical evidence on the issue of whether intravenous vitamin infusions constitute appropriate treatment of appellant's asthma condition.

Following Dr. Caliguiri's impartial medical opinion, Dr. Kerry provided additional medical narrative and referenced medical articles supporting the benefits of intravenous vitamin therapy. The Board has held that an additional report from an appellant's physician, which essentially repeats earlier findings and conclusions, is insufficient to overcome the weight accorded to an impartial medical specialist's report.⁴ Dr. Kerry was on one side of the conflict in medical opinion that gave rise to the impartial medical examination. Moreover, the Board has held that excerpts from publications have little probative value in resolving medical questions unless a physician shows the applicability of the general medical principles discussed in the articles to the specific factual situation at issue in the case.⁵ Dr. Kerry's additional medical reports are insufficient to overcome or to create a new conflict with the well-rationalized opinion of Dr. Caliguiri.

As the weight of the medical evidence of record supported that intravenous therapy was not appropriate for treatment of appellant's asthmatic condition, the Office properly terminated further payment for such therapy.

³ *Harry T. Mosier*, 49 ECAB 688 (1998); *Mary A. Moultry*, 48 ECAB 566 (1997).

⁴ *Michael Hughes*, 52 ECAB 387 (2001); *Thomas Bauer*, 46 ECAB 257 (1994).

⁵ *See Gloria J. McPherson*, 51 ECAB 441 (2000); *Ruby I. Fish*, 46 ECAB 276 (1994).

Accordingly, the decisions of the Office of Workers' Compensation Programs dated June 9, 2003 and July 22, 2002 are hereby affirmed.

Dated, Washington, DC
May 7, 2004

Alec J. Koromilas
Chairman

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member