United States Department of Labor
Employees' Compensation Appeals Board

S.O., Appellant	)	
and	)	**Docket No. 07-694**
	)	**Issued: June 26, 2007**
U.S. POSTAL SERVICE, POST OFFICE, Auburn, WA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 16, 2007 appellant filed a timely appeal from the September 14, 2006 decision of the Office of Workers' Compensation Programs terminating her wage-loss and medical benefits. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether the Office met its burden of proof to terminate appellant's compensation for wage-loss and medical benefits effective September 14, 2006.

FACTUAL HISTORY

On September 9, 2004 appellant, then a 41-year-old letter carrier, sustained a traumatic injury to her lower back when she bent over while seat belted in her vehicle to retrieve a piece of mail. On September 21, 2004 she was diagnosed with lumbar strain. Appellant has not worked since September 29, 2004. Her claim was accepted by the Office for a lumbar strain.

On October 19, 2004 appellant underwent a magnetic resonance imaging (MRI) scan, which revealed mild to moderate disc degeneration and broad-based disc herniation at L4-5, impingement of the L5 nerve root, and mild disc degeneration with desiccation and mild circumferential posterior bulging at L2-3. On October 25, 2004 Dr. Jos Cové, a Board-certified orthopedic surgeon, reviewed the MRI scan results and noted that they were "mostly long-standing changes, although the slight protrusion of L4-5 may be more recent." On physical examination, he found limited spinal range of motion, significant weakness in the left leg and hyperthesia in her left foot and shin. Dr. Cové found the amount of neural impingement to be relatively mild and recommended an epidural injection and physical therapy. He stated that appellant would not be able to return to work in her current condition.

Appellant began physical therapy on November 15, 2004 and underwent a transforaminal epidural injection on December 10, 2004. On December 16, 2004 she was released from physical therapy because the treatment was unlikely to improve her condition. On December 17, 2006 Dr. Cové reported that the epidural injections had provided only short-term relief. On December 21, 2004 he requested authorization for a L5 laminectomy and foraminotomy.

On December 28, 2004 the Office requested that Dr. Cové provide a rationalized medical opinion addressing appellant's employment injury to the diagnosed L5 radiculopathy and foot drop. Dr. Cové responded on January 4, 2005, stating that appellant had preexisting bulging discs and degenerative changes which were asymptomatic until her injury. He stated that appellant's leg symptoms and weakness were present from the time of the accepted employment injury and were thus employment related. On January 28, 2005 Dr. Cové stated that the relatively small disc herniation at L4-5 was significant enough to cause her current symptoms. He noted that even very minor injuries, such as the bending accident described by appellant, can lead to disc herniation and subsequent pinched nerve symptoms.

On January 25, 2005 Dr. Carlos Morávek, who is Board-certified in physical medicine and rehabilitation, conducted an electrodiagnostic evaluation of appellant's left lower extremity. He diagnosed severe acute left L5 radiculopathy based on definite acute denervation and minimal chronic reinnervation changes.

On March 1, 2005 the Office referred appellant to Dr. David Smith, an orthopedic surgeon, to determine the necessity of the requested laminectomy. Dr. Smith diagnosed bilateral L5 radiculopathy, secondary to L5-S1 herniated nucleus pulposus and degenerative disc disease. He found that the radiculopathy was directly caused by the accepted employment injury and that appellant's degenerative disc disease was aggravated by the injury. Dr. Smith opined that the requested laminectomy would relieve the symptoms related to appellant's radiculopathy, but was unlikely to resolve the low back pain associated with her degenerative disc disease. In her current condition appellant could do sedentary work and restricted from repetitive lifting over 10 pounds, walking over one half-hour at a time, repetitive stair climbing and squatting. On April 25, 2005 the Office authorized the spinal laminectomy, which was performed on March 28, 2005.

Following the surgery, appellant was referred to physical therapy for rehabilitation and work conditioning. On July 11, 2005 her therapy was interrupted by the onset of unrelated gastrointestinal symptoms that caused persistent nausea and vomiting. On September 21, 2005

Dr. Cové reported that appellant's gastrointestinal symptoms had improved, and that she was experiencing dull pain in both legs that was centered on her knees and feet. He stated that her back pain had not changed with surgery and that there was not a typical radicular pattern to her pain. Appellant exhibited a fair range of motion and x-rays of her spine were similar to those taken immediately after the surgery. Dr. Cové opined that degenerative changes played a role in her pain and spinal instability. He recommended a new spinal MRI scan and electromyogram of her lower extremities to determine the origin of her symptoms. On November 15, 2005 Dr. Cové released appellant to four hours of work per day with a maximum weight limit of 25 pounds. Appellant did not return to work.

On January 27, 2006 appellant underwent an MRI scan of her lumbar spine, which revealed degenerative disc disease, facet degenerative joint disease, mild left L4-5 neural foraminal stenosis, and an enlarged gallbladder. On February 3, 2006 Dr. Cové reported that appellant's foot drop had improved since her surgery and that her only current complaint was back pain, which increased with walking, activity and prolonged sitting. He reviewed appellant's MRI scan and noted preexisting degenerative changes at L2-3 and advanced degenerative changes at L4-5 with endplate edema. Dr. Cové opined that these findings were "relatively normal" and contained no evidence of neural impingement. He diagnosed chronic back pain with discogenic features and no radiculopathy. Dr. Cové noted that she had not yet completed the work conditioning physical therapy and he recommended a discography. He stated that surgical stabilization or fusion at L4-5 was an option for appellant.

On February 16, 2006 the Office referred appellant for a second opinion evaluation with Dr. Joan Sullivan, a Board-certified orthopedic surgeon. In a report dated March 20, 2006, Dr. Sullivan stated that appellant reported her pain as a dull constant ache that sometimes radiated up to her midthoracic spine. On physical examination, Dr. Sullivan reported that appellant could flex forward 50 degrees, extend 20 degrees, bend laterally 30 degrees on the right and left, rotate 30 degrees on the left without pain and rotate 20 degrees on the right with pain. She stated that the Waddell testing was "positive 3/4" with her reporting pain with right and left *en bloc* rotation, shoulder compression, light palpitation of the thoracic and lumbosacral spine, deep palpitation of the lumbar spine and palpitation of the right sacroiliac joint. Dr. Sullivan found full motor strength in the lower extremities, but noted somewhat inconsistent decreased sensation over the dorsum of the left foot.

Dr. Sullivan diagnosed lumbar strain with bilateral L5 radiculopathy secondary to an L5-S1 herniated disc, which she found to be industrially related and degenerative disc disease, which preexisted but was temporarily aggravated by the accepted injury. She noted that aggravation would have ceased three months following appellant's surgery and that the subsequent progression of her degenerative disc disease was not due to the surgery. Dr. Sullivan opined that residuals from the accepted September 9, 2004 injury had resolved and that any symptoms appellant currently had were caused by her preexisting disease. She stated that appellant could not return to her full-time duties without permanent restrictions on the amount of weight she could lift, carry or pull. Dr. Sullivan noted that appellant had a very strong disability conviction that would make it hard to return her to work. She did not recommend any further treatment.

On February 17, 2006 Dr. Cové completed a work capacity evaluation indicating that appellant could work in a light-duty position eight hours per day with restrictions on sitting,

walking, standing, pushing, pulling and lifting. He explained that she needed to change positions three times an hour. On April 11, 2006 Dr. Cové informed the Office that he disagreed with two of Dr. Sullivan's findings. He stated that appellant's condition, which he characterized as single-level disc degeneration and hypermobility at L4-5, was not a temporary aggravation. Dr. Cové also disagreed that appellant had reached maximum medical improvement and recommended a discogram to determine the cause of appellant's ongoing symptoms.

The Office found a conflict of medical opinion between Dr. Cové and Dr. Sullivan. On June 6, 2006 it referred appellant to Dr. Donald Hubbard, a Board-certified osteopath, selected as the impartial medical specialist. On July 14, 2006 Dr. Hubbard reviewed the medical record and conducted an impartial examination. He found that appellant had a normal gait, some limitations in thoracic range of motion and slight discomfort in the low back with *en bloc* rotation. Dr. Hubbard reported that in the straight leg raise test she experienced pain in her right low back in the supine position and was limited by tight hamstrings or sciatic tension. He stated that the reverse straight leg raise was positive bilaterally for midline L3-4 back pain. Dr. Hubbard found full motor strength in appellant's lower extremities, but noted tenderness to touch at the paraspinal muscles from L1 to the lumbosacral levels.

Dr. Hubbard stated that appellant's current diagnoses included multi-level degenerative disc disease and degenerative joint disease, right knee pain, and finger numbness, none of which were related to the accepted employment injury. He stated that the record was consistent with the historical diagnoses of lumbar strain and temporary acceleration and aggravation of preexisting asymptomatic lumbar degenerative disease and facet degenerative joint disease. Dr. Hubbard found that appellant had experienced acute compression of her left L5 spinal nerve root, which caused sciatica, radiculopathy and weakness in her left lower extremity. He stated that the compression was successfully treated with a laminectomy and partial facetectomy that caused no permanent structural damage to the spinal column. Appellant's current low back condition was consistent with the natural history and progression of degenerative disc disease and degenerative joint disease. Dr. Hubbard opined that appellant had recovered from her work-related injury and was therefore able to perform her date-of-injury position. He stated that no other medical treatment was needed to treat the work-related condition.

On August 3, 2006 the Office proposed termination of appellant's medical and wage-loss benefits based on Dr. Hubbard's opinion that she had no remaining disability or residuals related to her accepted employment injury. Appellant was given 30 days to submit additional evidence or arguments in opposition to this proposal.

On August 16, 2006 appellant disputed Dr. Hubbard's findings and had contacted Dr. Cové to review his report. No additional medical evidence was received by the Office.

By decision dated September 14, 2006, the Office terminated appellant's medical and wage-loss benefits. It found that Dr. Hubbard's opinion was entitled to the special weight of the medical evidence because it was rationalized and thorough.

LEGAL PRECEDENT

Once the Office has accepted a claim, it has the burden of justifying termination or modification of compensation benefits.[1] The Office may not terminate compensation without establishing that disability ceased or that it was no longer related to the employment.[2] The right to medical benefits is not limited to the period of entitlement to disability. To terminate authorization for medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition that require further medical treatment.[3]

The Federal Employees' Compensation Act provides that, if there is a disagreement between a physician making an examination for the United States and the physician of the employee, the Secretary must appoint a third physician to make an examination.[4] Likewise, the implementing regulation states that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an Office medical adviser or consultant, the Office must appoint a third physician to make an examination. This is called a referee examination and the Office is required to select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case.[5] It is well established that, when a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on proper factual and medical background, must be given special weight.[6]

ANALYSIS

The Office accepted appellant's September 21, 2004 traumatic injury claim for lumbar sprain. Appellant stopped working on September 29, 2004 and has not returned. The issue to be determined is whether the Office has met its burden of proof that appellant had no remaining disability or residuals when it terminated her benefits effective September 14, 2006.

The Office properly referred appellant to Dr. Hubbard, a Board-certified orthopedic surgeon, to resolve the conflict of medical opinion between Dr. Sullivan and Dr. Cové, both Board-certified orthopedic surgeons, as to whether her current condition was caused by her accepted employment injury. On July 14, 2006 Dr. Hubbard reviewed all the pertinent medical records and conducted a thorough impartial medical examination. He found that appellant had a normal gait, but that she had some limitations in thoracic range of motion and slight low-back pain during *en bloc* rotation. Dr. Hubbard reported that in the supine straight leg raise test she experienced pain in her right low back and was limited by tight hamstrings or sciatic tension and

[1] *Jorge E. Stotmayor*, 52 ECAB 105, 106 (2000).

[2] *Mary A. Lowe*, 52 ECAB 223, 224 (2001).

[3] *Frederick Justiniano*, 45 ECAB 491 (1994).

[4] 5 U.S.C. §§ 8101-8193, 8123(a).

[5] 20 C.F.R. § 10.321.

[6] *Gloria J. Godfrey*, 52 ECAB 486, 489 (2001).

that the reverse straight leg raise was positive bilaterally for midline L3-4 back pain. He found full motor strength in appellant's lower extremities, but noted tenderness to touch at the paraspinal muscles from L1 to the lumbosacral levels.

Dr. Hubbard found that appellant's current diagnoses of multi-level degenerative disc disease and degenerative joint disease were not related to her accepted employment injury. He stated that the record established that appellant sustained a lumbar strain and an acute compression of her left L5 spinal nerve root, which had temporarily accelerated and aggravated her preexisting conditions and caused sciatica, radiculopathy and weakness in her left lower extremity. Dr. Hubbard stated that the compression was successfully treated with a laminectomy and partial facetectomy and that the surgery caused no permanent structural damage to the spinal column. He found that appellant's current low back condition was consistent with the natural history and progression of degenerative disc disease and degenerative joint disease. Dr. Hubbard opined that appellant had recovered from her work-related injury, could work without restrictions and needed no further treatment for any residuals. The Board finds that the opinion of Dr. Hubbard is entitled to the special weight of the medical evidence because it is well rationalized and based on a thorough physical examination and review of the medical history.

The Office proposed termination of appellant's compensation based on Dr. Hubbard's opinion that appellant had no remaining disability or residuals related to her accepted employment injury. The Board finds that the Office properly relied on this opinion, which resolved the conflict of medical opinion between appellant's treating physician and the Office's second opinion physician. As Dr. Hubbard's report constitutes the special weight of the medical evidence, the Office met its burden of proof to terminate appellant's wage-loss and medical benefits.

CONCLUSION

The Board finds that the Office met its burden of proof to terminate appellant's compensation for wage-loss and medical benefits effective September 14, 2006.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated September 14, 2006 is affirmed.

Issued: June 26, 2007
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board