United States Department of Labor
Employees' Compensation Appeals Board

A.N., Appellant	)	
and	)	
NATIONAL AERONAUTICS SPACE ADMINISTRATION, OFFICE OF HUMAN RESOURCES & EDUCATION, Washington, DC, Employer	)	**Docket No. 07-2328** **Issued: April 22, 2008**

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 September 13, 2007 appellant filed a timely appeal from the August 14, 2007 decision of the Office of Workers' Compensation Programs denying his claim for back and neck pain and terminating his wage-loss compensation 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.

ISSUES

The issues are: (1) whether the Office properly terminated appellant's wage-loss compensation and medical benefits; and (2) whether appellant sustained an injury to his low back and neck causally related to the accepted condition or to factors of his federal employment.

FACTUAL HISTORY

On July 6, 1999 appellant, then a 48-year-old educational outreach specialist, filed an occupational disease claim alleging that his employment caused his depression. He realized that

his condition was work related on August 5, 1998. After intermittent absences starting in August 1998, appellant stopped working in September 2000. On December 6, 2000 the Office accepted his claim for major depression.

On January 12, 2001 appellant requested compensation for leave buyback and leave without pay taken intermittently from August 5, 1998. He claimed that he took the leave because of discomfort arising from his stress, which was being treated by both a chiropractor and a psychotherapist. Appellant provided the December 28, 2000 report of Dr. John Echeverry, a clinical psychologist, who stated that he was totally disabled for work from August 5 to 29, 1998 and April 20, 2000 forward for psychological reasons. Dr. Echeverry reported that Dr. Scott Schroth, a Board-certified internist, had referred appellant for both chiropractic and psychiatric treatment.

On February 9, 2001 the Office requested additional information about how appellant's work-related stress exacerbated his underlying low back pain and somatic conditions. On March 12, 2001 Dr. Larry Brown, a chiropractor, reported that he began treating appellant for recurring back pain on March 23, 1998. He stated that appellant's back pain was caused by subluxations of the fourth and fifth vertebrae, as diagnosed by x-ray. Dr. Brown indicated that appellant's condition was aggravated both by workplace occurrences as well as later discussions about those occurrences. He noted that appellant frequently sought urgent treatment for severe pain following psychotherapy sessions. Dr. Brown stated that, on these occasions, he treated appellant with chiropractic adjustments of the lumbar subluxations he found. He opined that a substantial degree of appellant's back pain was caused by tension-induced contractions that caused vertebral misalignment, which irritated the nerves in his back. Dr. Brown reviewed the compensable factors found by the Office and stated that he strongly suspected that appellant's bodily response to them would be similar to those that appellant referenced when he sought urgent treatment. He stated that appellant's condition, which improved to the point of not needing treatment in 1999, worsened in 2000.

On March 23, 2001 the Office placed appellant on the periodic rolls for wage-loss compensation.

On May 2, 2001 Dr. Schroth stated that he had followed appellant's symptoms of back pain, depression and dysthymic mood disorder for several years. He treated appellant's physical symptoms with anti-inflammatory medication, rest, heat, ice, exercise and referrals for chiropractic care and physical therapy. Dr. Schroth reported that there was no history of injury or trauma to appellant's back. He opined that appellant's episodes of back pain were related to periods of increased work stress or were exacerbated by his work stress.

On October 28, 2002 appellant was referred for a second opinion examination with an orthopedic surgeon to determine whether his back condition was related to his accepted depression. The statement of accepted facts provided to the orthopedic surgeon contained no information about the medical evidence discussing appellant's history of back pain. Appellant did not appear at the orthopedic examination.

On January 10, 2003 Dr. Echeverry stated that appellant's emotional condition would allow him to return to work following a six- to eight-week period of readjustment, during which

time he would work four hours per day and participate in supplemental therapy sessions. He noted that appellant's previous job no longer existed, but that he would be willing to evaluate any new positions for suitability.

On July 29, 2003 appellant underwent a second opinion examination by Dr. Robert Smith, a Board-certified orthopedic surgeon, who reviewed the May 2, 2001 report of Dr. Schroth and the March 12, 2001 report of Dr. Brown, and noted that there were no x-ray reports or original x-rays for review. He reported pain in his mid and low back, which arose around August 1998. On physical examination, Dr. Smith found that appellant's gait and station were normal and that he moved comfortably without evidence of back discomfort. He noted no spasms, atrophy, trigger points or deformity, but found some complaints of discomfort at the extreme edges of his range of motion. Dr. Smith's palpitation of the spine during motion revealed no spasms, rigidity or crepitation. He did not conduct any x-ray studies.

Dr. Smith stated that he found no evidence of organic abnormality in appellant's back. He disagreed with Dr. Brown's statement that appellant experienced tension-induced muscular contractions that caused vertebral malalignment because he found no clinical evidence of malalignment or deformity in the spine and no soft tissue abnormalities in the low back muscles. Dr. Smith opined that appellant did not have a back condition or residuals as a result of his accepted depression.

By decision dated September 9, 2003, the Office denied appellant's claim for compensation benefits for his back condition. The Office found that Dr. Smith carried the weight of the medical opinion evidence.

On October 9, 2003 appellant requested an oral hearing, before an Office hearing representative which was held on April 27, 2004. He stated that his back condition had been part of his claim from the beginning and that his physicians noted a connection between his stress and back pain. Appellant submitted additional medical evidence in support of his claim.

On October 21, 2003 appellant was examined by Dr. Warren Yu, a Board-certified orthopedic surgeon, who stated that appellant complained of mild low back pain. Dr. Yu found mild lumbosacral tenderness, but no malalignment, no spasm, full range of motion, normal gait, and no atrophy. An x-ray revealed mild narrowing at L5-S1, a congenital spina bifida occulta, and suggestions of unilateral pars defect on his obliques, but no spondylolisthesis. Dr. Yu diagnosed back pain with incidental spina bifida occulta and a likely pars defect on the right side of L5-S1. He found that appellant's back was stable and did not recommend any further treatment. An x-ray report prepared by a Dr. Kathleen Brindle, dated October 21, 2003, noted limited motion, particularly with extension, but no lumbar instability. Dr. Brindle stated that there was facet joint osteoarthritis in the lower lumbar spine and an incomplete fusion of the posterior elements at L5. She diagnosed facet joint osteoarthritis and limited range of motion.

On April 14, 2004 Dr. Schroth stated that appellant had a history of low back pain dating back over a decade. He stated that a 1997 x-ray revealed a congenital failure of fusion of the vertebral arch of L5-S1, leading to chronic spondylolisthesis of the lumbar spine. Dr. Schroth noted that appellant's psychological evaluations revealed that he suffered from chronic depression, which was manifested by somatization and somatic complaints, including low back

pain. Based on his knowledge of appellant's condition over the previous 10 years, he stated that appellant's somatic symptoms were frequently aggravated and exacerbated by periods of increased work stress. Dr. Schroth opined that appellant's underlying back pain was aggravated by work environment stressors from the mid to late 1990s.

On July 1, 2004 Dr. Yu provided a supplemental report, in which he stated that appellant's x-rays showed a mild narrowing of L5-S1 with congenital spina bifida at L5 and a unilateral pars defect on the right of L5, but no spondylolisthesis and no evidence of instability. He opined that the spina bifida occulta and unilateral pars defect could be the source of his persistent central back pain, and that this pain may be further exacerbated by the psychiatric disorders of depression and stress-related disorders.

By decision dated July 28, 2004, the Office hearing representative set aside the Office's September 9, 2003 decision and remanded the case for further medical development. She found that the report of Dr. Smith, the second opinion physician, was of diminished probative value because it was based on an inaccurate history and did not consider the congenital defects diagnosed by Dr. Yu. The Office hearing representative found that Dr. Brown was not a physician under the act because his diagnosis of spinal subluxation was not supported by other physicians who reviewed appellant's x-rays. She stated that, though the medical evidence of Dr. Schroth and Dr. Yu was not sufficient to establish that his back condition was related to his employment factors, it was sufficient to require further development of the evidence. The hearing representative stated that the Office should prepare an updated statement of accepted facts related to the claimed consequential back condition, including the date of pain onset and a more complete history of appellant's low back condition, including x-ray results and other diagnostic testing. Following referral to another second opinion examination, the Office should issue a new decision.

In response to the Office's request for additional information, Dr. Schroth provided medical records related to the treatment of appellant's back pain, beginning in 1996. On October 21, 1996 appellant reported abnormal sleeping patterns with increasing bilateral muscle aches in his arms, legs and back that coincided with stress at work. Dr. Schroth found tenderness and trigger points along the paraspinal muscles bilaterally. He provided no diagnoses, but suspected a fibromyalgia-type sleep disorder. On January 8, 1997 appellant reported back pain to an unidentified physician, who found normal range of motion and gait. Dr. Schroth diagnosed chronic back pain. An x-ray report dated December 31, 1997 revealed the failure of fusion in the arch of L5-S1, spondylolisthesis of L5-S1 on the left, and facet sclerosis and degenerative changes at L5-S1, right greater than left.

On February 2, 1998 Dr. Echeverry reported that he had been treating appellant intermittently since November 1996, when his symptoms included somatic complaints of aching in the extremities, neck and back. He diagnosed appellant with adjustment disorder with depression and anxiety. Dr. Echeverry stated that appellant's more serious symptoms improved with psychotherapy, but that he continued to be preoccupied with his health. On February 13, 1998 Dr. Schroth reported that appellant had recently been diagnosed with spondylolisthesis at L5-S1 with some chronic lower back discomfort. On October 24, 1998 he stated that appellant was experiencing recurrent right-sided low back pain and sciatica radiating down the lateral side.

On examination, Dr. Schroth found no tenderness, but noted a positive right-sided straight leg raising test. He diagnosed recurrent sciatica and chronic back pain.

In a report dated June 24, 1999, Dr. Schroth stated that appellant had a history of chronic intermittent low back pain and mild spondylolisthesis. Appellant's back pain worsened in early 1998 and the pain progressed through the summer, during which time he received frequent chiropractic treatments and physical therapy. Dr. Schroth opined that appellant's low back pain was exacerbated by work-related stress and worsening depression. On April 14, 2000 Dr. Echeverry stated that appellant's employment stress turned into physical symptoms on several occasions when he was discussing aspects of his employment during counseling sessions. In an undated report requested by a second opinion physician, Dr. Trudy Summers, a clinical psychologist, found that appellant had a tendency to somatize psychological pain or a vulnerability to physical problems.

On December 7, 2004 the Office requested clarification on the date of onset of appellant's low back complaints. On December 14, 2004 Dr. Schroth stated that appellant's back complaints began in 1997.

By decision dated January 28, 2005, the Office denied appellant's claim on the grounds that the medical evidence failed to establish that his back condition was causally related to the accepted condition or employment factors.

On April 28, 2005 appellant appealed the January 28, 2005 decision to the Board.[1] On January 17, 2006 the Office filed a motion to remand the case and cancel the oral argument on the grounds that it had not properly developed appellant's claim in accordance with the July 28, 2004 decision of the Office hearing representative. By decision dated February 1, 2006, the Board granted the Office's motion, set aside the January 28, 2005 decision and remanded the case for further medical development.

On January 3, 2007 the Office amended the statement of accepted facts to reflect that appellant claimed consequential injuries to his neck and mid and low back due to his accepted depression. On March 5, 2007 the Office referred appellant for a second opinion examination with Dr. Robert Draper, a Board-certified orthopedic surgeon.

On March 21, 2007 Dr. Draper reported that appellant experienced low back pain in 1996 or 1997 without any specific injury. Appellant stated that he was under psychological stress around the time he developed the back pain. Dr. Draper reviewed the October 21, 2003 x-rays of appellant's lumbar spine and found them to be normal. He also reviewed the x-rays conducted on December 31, 1997 and noted that they were normal, with the exception of some very minimal facet joint osteoarthritis as L5-S1 bilaterally. Dr. Draper reviewed Dr. Schroth's May 2, 2001 report and Dr. Smith's July 29, 2003 report. On physical examination, he found no spasms or tenderness in the spinal muscles and no abnormality in the spinal curvature. Appellant had normal reflexes, strength and sensation. Dr. Draper diagnosed neck and low back pain with no significant orthopedic pathology demonstrated on examination or by x-ray. He could find no orthopedic pathology to explain appellant's complaints because his clinical examination was

[1] Docket No. 05-1157 (April 28, 2005).

completely negative and the only abnormality noted on the x-rays was an amount of osteoarthritis at L5-S1 that would not be symptomatic. Dr. Draper stated that there were no orthopedic residuals associated with appellant's federal employment. He found that, from an orthopedic standpoint, appellant was able to work.

On April 27, 2007 the Office referred appellant for an impartial medical examination to resolve the conflict in medical evidence between Dr. Draper and appellant's treating physicians.

On May 30, 2007 Dr. John Cohen, the Board-certified orthopedic surgeon selected as the impartial medical specialist, examined appellant. He noted that appellant had a history of intermittent neck and back pain, for which he received treatment from Dr. Schroth on a yearly basis and Dr. Brown, a chiropractor, every two months. Appellant took no medication for his back condition. He was diagnosed with depression, for which he was treated on an ongoing basis by Dr. Echeverry without medication. On physical examination, Dr. Cohen found full and painless range of motion, along with normal motor function and reflexes, in the upper and lower extremities. Appellant complained of a change in sensation on his right thigh while sitting. He had normal range of motion in his cervical spine and his lumbar spine could flex past 90 degrees, extend 20 degrees and lateral bend 10 degrees on both sides without pain. Dr. Cohen took an x-ray of appellant's cervical spine and found that it revealed mild arthritis. The 1997 and 2003 x-rays of appellant's lumbar spine showed degenerative arthritis at L5-S1, particularly on the facet joints. On review of appellant's medical history, Dr. Cohen noted that appellant was treated by Dr. Brown from March to October 1998 for a diagnosed lumbar disc syndrome. He stated that there were no records regarding any specialists' treatment of appellant's back. Dr. Cohen stated that appellant was treated by Dr. Schroth from 1996 to 2001 with anti-inflammatory medication, rest, heat, ice, exercises, stress management and physical therapy. He noted that Dr. Schroth did not mention an incident that caused appellant's back problem.

Dr. Cohen diagnosed preexisting degenerative disc disease of the cervicocolumbar spine. He stated that the condition could not be related to appellant's employment since it was at multiple levels without history of injury. Dr. Cohen found that the medical evidence showed that appellant had back problems prior to his 1999 claim and presented no proof that he suffered consequential injuries related to that claim. He found that appellant was fit for employment in an office setting.

By decision dated August 14, 2007, the Office found that the special weight of the medical evidence, as constituted by Dr. Cohen's report, established that appellant had no consequential injuries to his back related to his accepted depression. The Office found that he was capable of returning to his preinjury position with stress level monitoring. It noted that, for administrative reasons, appellant had not returned to work and continued to receive compensation. The Office found that, because appellant was capable of working without restrictions related to his accepted work-related condition, he was no longer entitled to medical and compensation benefits. The Office terminated his medical and wage-loss compensation benefits effective August 15, 2007.

LEGAL PRECEDENT -- ISSUE 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 disability has ceased or that it is no longer related to the employment injury.[3]

The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability. To terminate authorization for medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition, which would require further medical treatment.[4]

ANALYSIS -- ISSUE 1

The Office accepted appellant's claim for major depression. The issue to be determined is whether the Office has met its burden of proof to establish that appellant has no remaining disability or residuals related to his accepted occupational disease.

The most recent psychological evidence in the record is Dr. Echeverry's January 10, 2003 report. He stated that appellant's emotional condition was such that he could return to work following a six- to eight-week readjustment period. During this time appellant would work four hours per day and participate in supplemental therapy sessions to help him return to employment successfully. Dr. Echeverry noted that appellant's previous job no longer existed, but that he was willing to evaluate a new position for suitability. In the four and a half years since this report was issued, the Office did not seek a second opinion or request an update from Dr. Echeverry on appellant's current psychological condition. The Board notes that Dr. Echeverry indicated that appellant would be able to return to full-time duties only after a period of adjustment and that he made no findings about whether appellant had residuals related to his accepted employment condition. The Board finds that this medical evidence is insufficient to establish that appellant had no remaining disability or residuals related to his accepted condition of depression.

Moreover, the Board notes that the record contains no notice of proposed termination that allowed appellant the opportunity to provide evidence of continuing entitlement to benefits prior to termination.[5] The Office procedures require a notice of proposed termination of compensation benefits in all cases when benefits are being paid on the periodic rolls and appellant has not died,

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[2] *Elaine Sneed*, 56 ECAB 373 (2005).

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

[4] *James F. Weikel*, 54 ECAB 690 (2003).

[5] *See Winton A. Miller*, 52 ECAB 405 (2001); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Periodic Review of Disability cases*, Chapter 2.812.3 (July 1993) ("when a claimant is receiving benefits on the periodic roll, benefits may not be terminated or reduced without giving the claimant prior notice and an opportunity to provide evidence of continuing entitlement, except in a limited set of circumstances").

returned to work, been convicted of defrauding the Office or failed to report earnings.[6] Office procedures also require notification prior to terminating all medical benefits.[7] The record establishes that appellant was on the periodic rolls and met none of the exceptions rendering notification unnecessary. The Board therefore finds that the Office did not provide proper notification prior to terminating appellant's wage-loss and medical benefits.

For the foregoing reasons, the Board finds that the Office did not properly terminate appellant's wage-loss and medical benefits, and thus failed to meet its burden of proof. On remand, the Office should restore the benefits.

LEGAL PRECEDENT -- ISSUE 2

An employee seeking benefits under the Federal Employees' Compensation Act[8] has the burden of establishing the essential elements of his or her claim, including the fact that the individual is an employee of the United States within the meaning of the Act; that the claim was filed within the applicable time limitation; that an injury was sustained while in the performance of duty as alleged; and that any disability or specific condition for which compensation is claimed is causally related to the employment injury.[9]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed;[10] (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition;[11] and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant.[12]

When determining whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors, the Office generally relies on the rationalized opinion of a physician.[13] To be rationalized, the opinion must be based on a complete factual and medical background of the claimant[14] and must be one of reasonable

[6] *See Winton A. Miller, supra* note 5; 20 C.F.R. § 10.503; Federal (FECA) Procedure Manual, Part 2 -- Claims, *Disallowances*, Chapter 2.1400.6a and c (March 1997).

[7] *Winton A. Miller, supra* note 5; Federal (FECA) Procedure Manual, Part 2 -- Claims, *Disallowances*, Chapter 2.1400.6b.

[8] 5 U.S C. §§ 8101-8193.

[9] *Caroline Thomas*, 51 ECAB 451 (2000); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[10] *Solomon Polen*, 51 ECAB 341 (2000).

[11] *Marlon Vera*, 54 ECAB 834 (2003); *Roger Williams*, 52 ECAB 468 (2001).

[12] *Ernest St. Pierre*, 51 ECAB 623 (2000).

[13] *Conard Hightower*, 54 ECAB 796 (2003); *Leslie C. Moore*, 52 ECAB 132 (2000).

[14] *Tomas Martinez*, 54 ECAB 623 (2003); *Gary J. Watling*, 52 ECAB 278 (2001).

medical certainty,[15] explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[16]

Regarding consequential injuries, the basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.[17]

The 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.[18] 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.[19] 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.[20]

ANALYSIS -- ISSUE 2

The Office denied appellant's claim for neck and back pain. The issue is whether appellant has met the burden of proof to establish that his back and neck conditions are related to either the accepted depression or to factors of his federal employment.

On April 14, 2004 Dr. Schroth, a Board-certified internist, reported that a 1997 x-ray revealed a congenital failure of fusion of appellant's L5-S1 vertebral arch, leading to chronic spondylolisthesis of the lumbar spine. He stated that appellant had diagnosed chronic depression, with symptoms of somatization and somatic complaints, including low back pain. Dr. Schroth stated that appellant's somatic symptoms were frequently aggravated and exacerbated by periods of increased work stress. He opined that appellant's underlying back pain was aggravated by his employment from the mid to late 1990s. On July 1, 2004 Dr. Yu, a Board-certified orthopedic surgeon, stated that an October 2003 x-ray showed mild narrowing at L5-S1 with congenital spina bifida and a right-sided pars defect at L5, but no spondylolisthesis and no evidence of instability. He opined that the spina bifida occulta and unilateral pars defect

[15] *John W. Montoya*, 54 ECAB 306 (2003).

[16] *Judy C. Rogers*, 54 ECAB 693 (2003).

[17] *S.M.*, 58 ECAB ___ (Docket No. 06-536, issued November 24, 2006) citing 1 Arthur Larson & Lex K. Larson, *Larson's Workers' Compensation Law* § 10.01 at p. 10-2 (2004).

[18] 5 U.S.C. §§ 8101-8193, 8123(a).

[19] 20 C.F.R. § 10.321.

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

could be source of appellant's persistent central back pain, and that this pain may be further exacerbated by the psychiatric disorders of depression and stress-related disorders.

On March 21, 2007 a second opinion physician, Dr. Draper, a Board-certified orthopedic surgeon, reviewed the October 21, 2003 x-rays of appellant's lumbar spine and found them to be normal. He also found the December 31, 1997 x-ray to be normal, with the exception of some very minimal facet joint osteoarthritis as L5-S1 bilaterally. Dr. Draper diagnosed neck and low back pain with no significant orthopedic pathology demonstrated on examination or by x-ray. He found no orthopedic pathology to explain appellant's complaints and opined that there were no orthopedic residuals associated with appellant's federal employment.

To resolve the conflict of medical opinion between Drs. Schroth and Yu and Dr. Draper, the Office referred appellant for an impartial medical examination. The Office selected Dr. Cohen, a Board-certified orthopedic surgeon as the impartial medical specialist, and provided him with appellant's case file. On May 30, 2007 Dr. Cohen noted that appellant had a history of intermittent neck and back pain, for which he received medical and chiropractic treatment but no medication, and diagnosed depression, for which he was treated on an ongoing basis. On physical examination, he found normal range of motion, motor function and reflexes in the upper and lower extremities. Appellant had normal range of motion in his cervical spine. His lumbar spine had flexion past 90 degrees, extension to 20 degrees, and lateral bending to 10 degrees on both sides without pain. Dr. Cohen's x-ray of appellant's cervical spine revealed mild arthritis. On review of the 1997 and 2003 lumbar spine x-rays, he found degenerative arthritis at L5-S1, particularly on the facet joints. Dr. Cohen noted that appellant was treated by a chiropractor for a lumbar disc syndrome in 1998 but that there was no evidence of specialist medical treatment for appellant's back. He stated that appellant was treated by Dr. Schroth from 1996 to 2001 with anti-inflammatory medication, rest, heat, ice, exercises, stress management and physical therapy. Dr. Cohen noted that Dr. Schroth did not mention an incident that caused appellant's back problem.

Dr. Cohen diagnosed preexisting degenerative disc disease of the cervicocolumbar spine. He opined that the condition could not be related to appellant's employment because it appeared at multiple levels of the spine without history of injury. Dr. Cohen found that the medical evidence established that appellant's back problems predated his 1999 claim and that it offered no proof that he suffered consequential injuries related to that claim. The Board finds that the opinion of Dr. Cohen is entitled to the special weight of the medical evidence because it was sufficiently well rationalized and based on proper factual and medical background.

The Board finds that appellant has not met the burden of proof to establish that his back condition was related to his diagnosed depression or the accepted factors of his employment.

CONCLUSION

The Board finds that the Office did not properly terminate appellant's wage-loss and medical benefits. The Board further finds that appellant has not established that he sustained an injury to his low back or neck causally related to factors of his federal employment.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated August 14, 2007 is reversed in part and affirmed in part, in accordance with this decision.

Issued: April 22, 2008
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