United States Department of Labor
Employees' Compensation Appeals Board

K.M., Appellant	)	
and	)	**Docket No. 09-1127**
	)	**Issued: April 12, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Houston, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 24, 2009 appellant filed a timely appeal from the January 7, 2009 nonmerit decision of the Office of Workers' Compensation Programs, which denied her request for reconsideration. She also timely appealed the Office's April 3, 2008 decision, which denied modification of a January 2, 2008 decision terminating compensation benefits. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUES

The issues are: (1) whether the Office properly terminated appellant's compensation benefits effective December 22, 2007; (2) whether appellant had any residuals or disability after December 22, 2007; and (3) whether the Office properly denied her request for reconsideration pursuant to 5 U.S.C. § 8128(a).

FACTUAL HISTORY

On October 5, 2006 appellant, then a 39-year-old letter carrier, tripped and fell over a pallet and injured her right shoulder, wrist and knee while in the performance of duty. She stopped work on October 11, 2006. The Office accepted the claim for lumbar sprain, right shoulder sprain and cervical sprain. Appellant received appropriate compensation benefits.

On November 2, 2006 Dr. Marvin Chang, Board-certified in pain medicine, treated appellant for neck and low back pain. He diagnosed cervical and lumbar sprain and strain. Dr. Chang recommended continued physical therapy. On November 17, 2006 he advised that appellant related that she was doing better with therapy but continued to have numbness and tingling, which was improving slowly. Dr. Chang completed an attending physician's report and checked a box "yes" to indicate that appellant's condition was employment related. He opined that she was totally disabled for work since the date of injury.

In a letter dated January 9, 2007, the Office requested Dr. Chang to provide an opinion about appellant's ability to work. In a January 19, 2007 report, Dr. Chang advised that appellant was seen for chronic pain secondary to shoulder, neck and low back pain. Appellant described a progressive increase in pain, especially in the neck and shoulder areas, which was intolerable. Dr. Chang noted that appellant appeared to be worsening and recommended diagnostic testing. In January 29, 2007 reports, Dr. James A. Cain, a Board-certified diagnostic radiologist, advised that a magnetic resonance imaging (MRI) scan of the right shoulder showed moderate cuff tendinitis but no tear. An MRI scan of the cervical spine showed a normal appearing craniocervical junction, cord and marrow signal. There was no evidence of disc herniation at C7-T1. At C4-5, there was a three-millimeter broad-based posterior protrusion that indented the cord. There was moderate central canal stenosis and moderate right and mild left foraminal narrowing. Other levels had lesser protrusions that did not indent the cord.

In a letter dated April 26, 2007, the Office requested that Dr. Chang provide a written treatment plan and details for returning appellant to work. He did not respond.

On May 4, 2007 the Office referred appellant to Dr. Bernard Albina, a Board-certified orthopedic surgeon, for a second opinion examination. In a report dated June 6, 2007, Dr. Albina reviewed appellant's history of injury and medical treatment. He determined that appellant was able to return to her regular duties. Dr. Albina found that appellant no longer had any residuals of the accepted lumbar, cervical or right shoulder strains.

In a letter dated June 18, 2007, the Office provided Dr. Chang with Dr. Albina's report and requested an opinion regarding appellant's current condition. Dr. Chang did not respond.

On July 19, 2007 the Office referred appellant to Dr. James Hood, a Board-certified orthopedic surgeon, for a second opinion examination regarding appellant's accepted condition and work restrictions.[1] In a report dated August 22, 2007, Dr. Hood reviewed appellant's history of injury and medical treatment. He examined appellant and noted complaints of neck pain radiating into the posterior aspect of both shoulders, right greater than left, with some lower back discomfort. Dr. Hood examined appellant's right shoulder and found abduction at 175 degrees. Appellant had full forward flexion of 180 degrees and normal internal and external rotation. Dr. Hood found no measurable atrophy of the upper or lower arm, right versus left. Examination of the lumbar spine revealed no palpable muscle spasm and forward flexion of 90 degrees. Sitting straight leg raise was normal to 90 degrees bilaterally with normal muscle strength bilaterally in all groups and normal knee and ankle reflexes bilaterally.

[1] In a July 18, 2007 memorandum, the Office noted that the reason for a referral was for a second opinion.

Regarding the cervical spine, Dr. Hood advised that appellant's examination was normal. He found that she had normal upper extremity muscle strength bilaterally. Dr. Hood noted that appellant underwent a functional capacity evaluation which found that she was capable of light to medium work, with lifting of 1 to 10 pounds, frequent lifting of 10 to 20 pounds, and occasional lifting of 20 to 30 pounds. He stated that appellant could "now return safely and perform all the expected duties as indicated." Dr. Hood did not believe that appellant incurred any significant injury, damage or harm to the rotator cuff that would preclude her from doing repetitive lifting. He found that appellant no longer had any residuals of the October 5, 2006 injury and reached maximum medical improvement. Dr. Hood noted that appellant's examination was normal and she did not have any permanent impairment due to the accepted conditions.

An August 15, 2007 functional capacity evaluation (FCE) from Occupational Health Systems was received by the Office on August 29, 2007. The report noted that, during some of the tests, appellant exhibited "submaximal effort."

On October 17, 2007 Dr. Hood clarified his opinion on appellant's work capacity. He referred to the FCE and noted that appellant gave a "less than maximum effort." Dr. Hood found that, while the report provided some limitations, he must base his opinion on the history of injury, the actual injury and her current physical findings. Although appellant complained of neck, back and right shoulder pain, "the imaging studies did not reveal any injury (damage or harm)." Dr. Hood opined that appellant had a "one-time event producing subjective complaints of discomfort in these areas. However, there is nothing to suggest that she had any true or significant injury." Dr. Hood reiterated that appellant's physical examination was normal, she had excellent motion of the neck and back, and her shoulder motion was nearly normal. He did not find that appellant suffered any significant injury as a result of the work event that would preclude her from returning to work full duty without restrictions. The findings of the functional capacity evaluation in which she gave a less than maximum effort did not alter his conclusion. Dr. Hood opined that he could not make an assessment of her work abilities based on the FCE alone because it was only beneficial to show that appellant did not give a maximum effort and was not indicative of her true abilities. He reiterated that appellant could return to work full duty without restrictions. In an accompanying October 17, 2007 work capacity evaluation form, Dr. Hood reiterated that appellant could return to her usual job.

Dr. Chang submitted additional reports advising that appellant's condition had not resolved from December 15, 2006 to September 14, 2007. He noted that appellant was seen for chronic pain secondary to cervical disc herniation with radiculitis. Appellant related complaints of continued neck and bilateral radicular symptoms, particularly into her right upper extremity. Dr. Chang stated that the MRI scan of her cervical spine revealed a three millimeter disc herniation with nerve root impingement at the level of C4-5 and a small disc herniation at the C5-6 level. He recommended a cervical epidural steroid injection. Dr. Chang noted that his physical examination showed positive impingement sign on the right indicated by Spurling's test. He opined that appellant was being seen for chronic pain secondary to cervical disc herniation with radiculitis. In an August 15, 2007 work capacity evaluation, Dr. Chang indicated that appellant was unable to work eight hours per day. He stated that maximum medical improvement had not been reached.

The Office also received a February 12, 2007 electromyography report from Dr. William High, a Board-certified neurologist, who noted that appellant had C6 nerve root irritation resulting in mild C6 radiculitis on the left. It also received several reports from Dr. Paul Raymond, a chiropractor, dated from October 11, 2006 to October 25, 2007. Dr. Raymond diagnoses right shoulder tendinitis/bursitis, right knee contusion, cervical sprain/strain, cervical radiculitis and lumbar sprain/strain. He recommended continuing with Dr. Chang for medication management and four to six weeks of therapy.

On November 7, 2007 the Office proposed to terminate appellant's compensation benefits on the basis that the weight of the medical evidence, as represented by the report of Dr. Hood, which it identified as an impartial medical examiner, established that appellant had no continuing disability as she had fully recovered from her accepted conditions and was able to return to her regular duties. It noted that a conflict had arisen between appellant's physician, Dr. Chang, and the second opinion, Dr. Albina, regarding whether appellant could return to her regular duties and whether she had continued residuals of her accepted conditions.

In response to the notice of proposed termination, the Office received additional medical evidence which included reports from Dr. Chang dating from June to November 2007. In a June 22, 2007 report, Dr. Chang indicated that he disagreed with Dr. Albina's opinion that appellant's conditions had resolved and that she could return to her regular duties. He noted that diagnostic test results revealed a protrusion and encroachments at C5-6.

The Office received a November 1, 2007 report in which Dr. Chang diagnosed cervical disc herniation and cervical radiculopathy and administered a cervical epidural steroid injection. In a November 16, 2007 report, Dr. Chang noted that appellant was seen for follow up of chronic pain secondary to cervical disc herniation with radiculopathy. He noted that appellant was doing much better with the steroid injection. Dr. Chang indicated that appellant wished to proceed with a final epidural steroid injection. The Office received several notes from chiropractor, Dr. Raymond, dating from January 4 through November 1, 2007.

By decision dated January 2, 2008, the Office terminated appellant's compensation benefits effective December 22, 2007, on the grounds that appellant had no continuing residuals of her employment injury. Dr. Hood was characterized as a referee physician.

On January 21, 2008 appellant requested reconsideration. She indicated that she was still in need of medical treatment as a result of her work injury. Appellant submitted copies of previously submitted documents and new evidence. In a January 11, 2008 report, Dr. Chang noted that appellant was seen for follow up due to chronic pain that was secondary to cervical disc herniation radiculopathy. He indicated that he would try to maintain her on medical management while her case was being appealed. In a March 7, 2008 duty status report, Dr. Chang diagnosed cervical sprain/strain, shoulder tendinitis and knee contusion of the wrist. He indicated that appellant was totally disabled.

In a January 26, 2008 report, Dr. Richard Francis, an orthopedic spine surgeon, diagnosed cervical disc herniation at C4-5 and bilateral upper extremity radicular symptoms. He recommended additional testing to include a pressure controlled pain provocative discogram to evaluate the disc space. Dr. Francis noted there was reason to believe that the herniated disc at

the C4-5 level could contribute significantly to her midaxial neck pain, which seemed to be the predominant problem.

Appellant also submitted a January 4, 2008 report from Dr. James Flower, a licensed professional counselor, who diagnosed adjustment disorder with mixed anxiety and depressed mood and stated that appellant should continue with her medical treatment.

In an April 3, 2008 decision, the Office denied modification of its prior decision. On November 21, 2008 appellant requested reconsideration. In support of her request, the Office received copies of previously submitted reports from Dr. Chang dated August 9 and November 1, 2007.

In a January 7, 2009 decision, the Office denied appellant's request for reconsideration finding that there was insufficient evidence to warrant a merit review of the claim.

LEGAL PRECEDENT -- ISSUE 1

Once the Office accepts a claim and pays compensation, it bears the burden to justify modification or termination of benefits.[2] Having determined that an employee has a disability causally related to his or her federal employment, the Office may not terminate compensation without establishing either that the disability has ceased or that it is no longer related to the employment.[3] The right to medical benefits for an accepted condition is not limited to the period of entitlement to compensation for disability.[4] To terminate authorization for medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition which require further medical treatment.[5]

The Federal Employees' Compensation Act[6] provides that, if there is disagreement between the physician making the examination for the Office and the employee's physician, the Office shall appoint a third physician who shall make an examination.[7] In cases where the Office has referred appellant to an impartial medical examiner to resolve a conflict in the medical evidence, the opinion of such a specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[8]

[2] *Curtis Hall*, 45 ECAB 316 (1994).

[3] *Jason C. Armstrong*, 40 ECAB 907 (1989).

[4] *Furman G. Peake*, 41 ECAB 361, 364 (1990); *Thomas Olivarez, Jr.*, 32 ECAB 1019 (1981).

[5] *Calvin S. Mays*, 39 ECAB 993 (1988).

[6] 5 U.S.C. §§ 8101-8193, 8123(a).

[7] *Id.* at § 8123(a); *Shirley L. Steib*, 46 ECAB 309, 317 (1994).

[8] *Gloria J. Godfrey*, 52 ECAB 486 (2001); *Gary R. Sieber*, 46 ECAB 215, 225 (1994).

ANALYSIS -- ISSUE 1

The Office accepted the claim for lumbar sprain, right shoulder sprain and cervical sprain. It terminated appellant's compensation benefits effective December 22, 2007 on the grounds that she had no continuing residuals of her employment injury.

The Board finds that this case is not in posture for decision due to a conflict in the evidence regarding whether appellant continued to have residuals from her accepted employment injury. This conflict is between Dr. Chang, an attending physician and Board-certified in pain medicine, who advised that appellant continued to have residuals from her employment injury and Dr. Hood, a Board-certified orthopedic surgeon serving as a second opinion physician, who indicated that she no longer had any residuals. In its November 7, 2007 notice of proposed termination and its January 2, 2008 termination decision, the Office erroneously referred to Dr. Hood as an impartial medical specialist. Dr. Hood actually served as a second opinion physician as demonstrated by the Office's July 19, 2007 referral letter. The Board has found that there is no provision in the Act, the Office's regulations or its procedures for designating a physician an impartial medical evaluator on an after the fact basis.[9] Thus, Dr. Hood was not an impartial medical specialist and his report is not entitled to special weight.

In this case, Dr. Chang, the treating physician, submitted reports in which he indicated that appellant's condition had not resolved. In his March 6, 2007 report, he noted that appellant was seen for chronic pain secondary to cervical disc herniation with radiculitis. Dr. Chang noted that her recent MRI scan of her cervical spine revealed a three millimeter disc herniation with nerve root impingement at the level of C4-5 and a small disc herniation at the C5-6 level. He noted examination findings which revealed a positive impingement sign on the right. In his August 15, 2007 work capacity evaluation, Dr. Chang indicated that appellant was unable to return to work for eight hours per day. He also indicated that maximum medical improvement had not been reached. Dr. Chang continued to treat appellant and disagreed that appellant could return to her regular duties.

In contrast, Dr. Hood, the second opinion physician, a Board-certified orthopedic surgeon, saw appellant on August 22, 2007. He noted examination findings and concluded that her examination was normal. Regarding the cervical spine, Dr. Hood indicated that appellant's examination was normal. He also indicated that appellant had normal upper extremity muscle strength bilaterally. Dr. Hood indicated that functional capacity evaluation revealed that appellant was capable of light to medium work and opined that appellant could "now return safely and perform all the expected duties as indicated." He opined that appellant no longer suffered from any residuals of the event of October 5, 2006 and reached maximum medical improvement. Dr. Hood noted that appellant's examination was "so normal that she would have no impairment rating." In his October 17, 2007 supplemental report, he referred to the FCE and noted that appellant gave a "less than maximum effort." Dr. Hood explained that while appellant

[9] *See Joanne S. Rozelle*, 40 ECAB 931, 939 (1989). *See also David Alan Patrick*, 46 ECAB 1020, 1024 (1995); *Henry J. Smith, Jr.*, 43 ECAB 524 (1992), *reaff'd on recon.*, 43 ECAB 892 (1992) (when the Office does not notify a claimant of a physician's status as an impartial medical examiner, that physician may not serve as the impartial medical examiner; Office procedures are intended to assure a claimant's knowledge that a physician is an impartial medical examiner so that he or she may then choose to exercise the procedural right to participate in the selection of the impartial medical examiner).

complained of neck, back and right shoulder pain, "the imaging studies did not reveal any injury (damage or harm)." He opined that "there is nothing to suggest that she had any true or significant injury." Dr. Hood dismissed the FCE as he suggested it only supported that she did not give a maximum effort, and thus the test was not indicative of her true abilities. He repeated that appellant could return to work full duty without restrictions.

As a conflict in the medical evidence existed between the opinions of Drs. Chang and Hood at the time the Office terminated compensation benefits, the Office did not meet its burden of proof to terminate appellant's benefits.

CONCLUSION

The Board finds that the Office did not meet its burden of proof in terminating appellant's compensation benefits effective December 22, 2007.[10]

ORDER

IT IS HEREBY ORDERED THAT the January 7, 2009 and April 3, 2008 decisions of the Office of Workers' Compensation Programs are reversed.

Issued: April 12, 2010
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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

[10] In light of the Board's resolution on the first issue, the second and third issues are moot.