United States Department of Labor
Employees' Compensation Appeals Board

D.M., Appellant	)	
and	)	**Docket No. 09-1477**
	)	**Issued: February 23, 2010**
DEPARTMENT OF JUSTICE, BUREAU OF PRISONS, Brooklyn, NY, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On May 26, 2009 appellant filed a timely appeal from the October 16, 2008 and May 6, 2009 merit decisions of the Office of Workers' Compensation Programs concerning the termination of his compensation. 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 effective October 26, 2008 on the grounds that he had no residuals of his November 29, 2000 employment injury after that date.

FACTUAL HISTORY

The Office accepted that on November 29, 2000 appellant, then a 35-year-old special agent, sustained sciatica, cervical sprain, bilateral lumbar radiculopathy and lumbar sprain when he fell on stairs. Appellant stopped work intermittently and the Office paid him compensation for periods of disability.

In December 2000 appellant came under the care of Dr. Nahad Owaid, a Board-certified physical medicine and rehabilitation physician. On May 9, 2006 Dr. Owaid stated that appellant had been complaining of lower back pain radiating to both lower extremities associated with numbness and weakness. He noted that since appellant sustained a work-related accident on November 29, 2000, he had been diagnosed with a herniated disc at L4-5 and impingement of the bilateral L5 nerve root. Dr. Owaid indicated that appellant presently was on total disability and that he was unable to perform any work duties. On examination he had tenderness at L4-5 and decreased bilateral big toe motion on extension. Dr. Owaid stated that appellant "has sustained casually-related injuries in a work-related accident, which occurred on November 29, 2000. Appellant continued the need of pain medication." In form reports dated March 19, 2007 and March 20, 2008, Dr. Owaid detailed permanent restrictions. The forms did not specify any diagnosed medical conditions.

Given the limited reports from attending physicians,[1] the Office referred appellant to Dr. Jeffrey C. Pollack, a Board-certified neurologist, for evaluation of whether he continued to have residuals of his November 29, 2000 work injury.

On May 22, 2008 Dr. Pollack detailed appellant's medical history, including the November 29, 2000 work injury, and noted that he complained of lower back pain radiating into the entirety of both legs, pain extending from his neck to his head (more on the right), and diffuse numbness of both legs, most notably in the entire left leg and intermittently in the entire right leg. He indicated that magnetic resonance imaging (MRI) scan testing of the low back obtained between January and April 2004 showed minor discogenic changes but no evidence of clear nerve root involvement. An April 27, 2001 MRI scan testing of the cervical spine showed a central disc bulge at C5-6 without evidence of nerve root impingement or spinal cord compression. Dr. Pollack reported his findings on physical examination noting that neck and back motion was moderately limited secondary to pain complaints. Sensory examination showed diminished pinprick sensation of the entirety of the left arm and leg in no organic pattern. Dr. Pollack stated that appellant's clinical examination was notable for extensive signs of nonorganic disability. He had sensory loss of the entirety of the left side of his face, head, neck, arm and leg as well as give-way weakness of all muscles of the left upper and left lower extremity. None of these findings fit either a peripheral nerve or radicular pattern and clearly suggested exaggerated symptomatology.

Dr. Pollack advised that he did not document a single objective finding to correlate with lumbar or cervical radiculopathy. He noted that appellant's MRI scan testing appeared to show a small left-sided disc protrusion/herniation at L4-5, but he could not clearly see a nerve root impingement and appellant's clinical symptomatology did not fit a finding of such impingement in any way. There were no objective findings to support the conclusion that any residuals of appellant's November 29, 2000 work injury were still present. Dr. Pollack noted that appellant's multiple nonobjective symptoms and signs on examination were not likely to resolve given his long-standing disability and he indicated that he could not find any objective neurological source for these complaints. He stated that there was no indication for any neurological intervention and posited that the majority of his findings suggested an exaggerated nonorganic

[1] The Office periodically requested that appellant provide medical reports from attending physicians.

symptornatology. Dr. Pollack noted, "From a neurological perspective, I have no treatment to offer him at this point. From an objective neurological basis, I frankly d[o] believe he is capable of returning to work full time without restrictions. However, again based on his multiple nonorganic subjective complaints, I do not feel that he is likely to do this."[2]

In an August 22, 2008 notice, the Office advised appellant that it proposed to terminate his compensation for wage-loss compensation and medical benefits on the grounds that he no longer had residuals of his November 29, 2000 employment injury. It based the proposed termination on the opinion of Dr. Pollack and advised appellant that he had 30 days to submit evidence and argument challenging the proposed action.

Appellant submitted the findings of a September 9, 2008 MRI scan test of his low back. The impression section of the study indicated that compared to a January 25, 2001 MRI scan study there is no significant interval change. There was partial sacralization of the L5 vertebrae and degeneration, bulge, and central disc herniation at the L4-5 level contributing to mild to moderate central stenosis. There was also a moderate bilateral foraminal compromise at this level.

The Office provided Dr. Pollack with the September 9, 2008 MRI scan test and asked him to indicate whether this evidence changed his opinion. On September 23, 2008 Dr. Pollack reviewed the September 9, 2008 MRI scan test as showing similar findings to an earlier study from January 2001 which he had previously reviewed. His review of the earlier MRI scan did not show evidence of nerve root impingement and he saw nothing in the new MRI scan to change his earlier opinion. Dr. Pollack stated:

> "I do refer you to my earlier impression for that opinion. Again, the patient has sensory loss of the entirety of the left side of his face, head, neck, arm and leg, as well as give way weakness of the left upper and left lower extremity clearly suggesting exaggerated symptomatology. The patient's lumbar MRI scan, in my opinion, failed to show evidence of clear nerve root impingement and in any case that would not be an explanation for his multiple symptoms and exaggerated signs…. I do believe he has reached maximum medical improvement from a neurological perspective, specifically related to the accident of November 29, 2000. In my opinion, further neurological treatment and testing are neither indicated nor necessary. I do believe he is capable of working full time without restrictions from a neurological point of view."

In an October 16, 2008 decision, the Office terminated appellant's compensation for wage-loss compensation and medical benefits effective October 26, 2008 on the grounds that he no longer had residuals of his November 29, 2000 work injury.

Appellant requested a telephone hearing with an Office hearing representative. At the February 10, 2009 hearing, appellant testified that he remained disabled due to his work-related back condition. He submitted reports from December 2008 and February 2009 from

[2] Dr. Pollack completed a form in which he indicated that appellant could perform his regular work without restrictions for eight hours per day.

Dr. Kaixuan Lui, an attending Board-certified orthopedic surgeon, who recommended back surgery. He also submitted reports showing that he had low back surgery in March 2003.

In a May 6, 2009 decision, the Office hearing representative affirmed the October 16, 2008 decision. She found that the weight of the medical evidence was the opinion of Dr. Pollack.

LEGAL PRECEDENT

Under the Federal Employees' Compensation Act,[3] once the Office has accepted a claim it has the burden of justifying termination or modification of compensation benefits.[4] The Office may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.[5] The Office's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[6]

ANALYSIS

The Office accepted that on November 29, 2000 appellant sustained sciatica, cervical sprain, bilateral lumbar radiculopathy and lumbar sprain when he fell on stairs. It terminated appellant's compensation effective October 26, 2008 based on the May 22 and September 23, 2008 reports of Dr. Pollack, a Board-certified neurologist who served as an Office referral physician.

The Board finds that the opinion of Dr. Pollack establishes that appellant had no disability due to his November 29, 2000 employment injury after October 26, 2008. In his May 22, 2008 report, Dr. Pollack reported his findings on examination and noted that the clinical examination was notable for extensive signs of nonorganic disability. Appellant had sensory loss of the entirety of the left side of his face, head, neck, arm and leg as well a give-way weakness of all muscles of the left upper and left lower extremity. Dr. Pollack found that none of these findings fit either a peripheral nerve or radicular pattern and clearly suggested exaggerated symptomatology. He further indicated that he did not document a single objective finding to correlate with lumbar or cervical radiculopathy. Dr. Pollack noted that appellant's MRI scan testing appeared to show a small left-sided disc protrusion/herniation at L4-5, but he could not clearly see a nerve root impingement and appellant's clinical symptomatology did not fit a finding of such impingement in any way. He concluded that appellant did not have any residuals of his November 29, 2000 work injury and that he was capable of performing his regular work from a neurological standpoint. In a supplemental report dated September 23, 2008, Dr. Pollack indicated he reviewed the findings of the September 9, 2008 MRI scan testing of appellant's low back and found no significant changes from a January 2001 study. He indicated, therefore, that

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[3] 5 U.S.C. §§ 8101-8193.

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

[5] *Id.*

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

this new study did not change his earlier opinion that appellant ceased to have work-related residuals.

The Board has carefully reviewed the opinion of Dr. Pollack and notes that it has reliability, probative value and convincing quality with respect to its conclusions regarding the relevant issue of the present case. Dr. Pollack based his opinion on a thorough factual and medical history and he accurately summarized the relevant medical evidence.[7] Dr. Pollack provided medical rationale for his opinion by explaining that there were no objective findings to support the conclusion that any residuals of appellant's November 29, 2000 work injury were still present. Dr. Pollack noted that appellant's multiple nonobjective symptoms and signs on examination were not related to the accepted conditions. He concluded that any inability to work would be due to these nonwork-related factors.

The record contains a May 9, 2006 report in which Dr. Owaid, a Board-certified physical medicine and rehabilitation physician, indicated that appellant had problems related to his L4-5 disc and was totally disabled. In form reports dated March 19, 2007 and March 20, 2008, Dr. Owaid detailed permanent restrictions, but the forms did not identify any diagnosed medical conditions. The Board notes that these reports are of limited probative value on the issue in this case in that they do not contain a clear opinion that appellant's continuing problems were related to the November 29, 2000 work injury. Moreover, the forms provide only limited information of examination findings. In December 2008 and February 2009 reports, Dr. Lui, an attending Board-certified orthopedic surgeon, recommended back surgery.[8] Dr. Lui did not provide any opinion that a work-related condition necessitated this surgery.

For these reasons, the Office properly terminated appellant's compensation effective November 29, 2000 based on the opinion of Dr. Pollack.

CONCLUSION

The Board finds that the Office met its burden of proof to terminate appellant's compensation effective October 26, 2008 on the grounds that he no longer had residuals of his November 29, 2000 employment injury after that date.

[7] *See Melvina Jackson*, 38 ECAB 443, 449-50 (1987); *Naomi Lilly*, 10 ECAB 560, 573 (1957).

[8] Appellant also submitted reports showing that he had low back surgery in March 2003.

ORDER

IT IS HEREBY ORDERED THAT the May 6, 2009 and October 16, 2008 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: February 23, 2010
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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