United States Department of Labor
Employees' Compensation Appeals Board

K.M., Appellant	)	
and	)	**Docket No. 10-695**
	)	**Issued: January 25, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Haiku, HI, Employer	)	

Appearances:
Patrick K. Wong, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On January 12, 2010 appellant filed a timely appeal from a July 21, 2009 merit decision of the Office of Workers' Compensation Programs. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over this case.

ISSUE

The issue is whether the Office met its burden of proof to terminate appellant's monetary compensation on December 15, 2008 on the grounds that she was no longer disabled due to a May 31, 2008 employment injury.

On appeal, appellant's attorney asserts that her attending osteopath was pressured by federal agents to render an opinion without considering the extent of appellant's employment injury.

FACTUAL HISTORY

On May 31, 2008 appellant, then a 50-year-old rural carrier associate, sustained a laceration to the right side of her face when her head struck a metal frame in a postal vehicle.

She was backing up on a dirt road and hit a large pothole. A May 31, 2008 emergency room report described the injury as a one-inch right eyebrow laceration that was sutured by a Dr. Perez. Appellant was discharged home.[1] The employing establishment controverted the claim. A June 23, 2008 computerized tomography (CT) scan of the head was interpreted as normal. On June 27, 2008 the Office accepted an open wound of the right forehead, without complications and she received compensation.

In a June 30, 2008 report, Dr. Steven T. Farmer, an osteopath practicing family medicine, noted appellant's complaints of diplopia (double vision) and vertigo due to a motor vehicle accident the previous month. He provided findings on examination and diagnosed diplopia, vertigo, cervical strain and healed laceration of the right eyelid. Dr. Farmer recommended that appellant see an ophthalmologist and advised that she could return to work on July 7, 2008. On July 30, 2008 he noted that she had severe positional vertigo, pain in the right eye with bending, loss of vision and loss of memory. Dr. Farmer recommended that appellant be seen by a neurologist and advised that she could not work.

By report dated September 18, 2008, Dr. Thomas Drazin, a neurologist, noted the history that appellant struck her head when she backed into a pothole. He listed her complaint of a tingly sensation in the right lateral temple and dizziness, particularly with positional change. Neurological examination demonstrated that recent and remote memory were good with no cognitive deficits in conversation, nystagmus to end-gaze, more on the right than left and dizziness with turning on gait. Videonystagmography testing revealed evidence consistent with a postconcussive labyrinthitis affecting the peripheral vestibular system and not the central vestibular system. Dr. Drazin diagnosed postconcussive vestibulopathy with improving symptoms and no evidence for significant cortical postconcussive syndrome. He advised that overall prognosis was good with no further testing warranted and recommended that she return to her eye doctor.

On October 7, 2008 the employing establishment inspector general's office submitted an investigation report and attached memoranda of activity dated August 8 through September 14, 2008 with a surveillance video.[2] An inspector general agent observed appellant frequently bending, stooping, exercising at a gym for several hours at a time, walking up three flights of stairs to her residence, carrying boogie boards and beach equipment, taking long walks on the beach, swimming, snorkeling and driving a motor vehicle to most activities. The agent reported that she did not demonstrate any apparent signs of pain or discomfort or signs of dizziness or blurry vision while she performed daily life activities, such as walking, driving and carrying numerous items in both hands. He reported that appellant also showed no discomfort while performing numerous leisure activities, including swimming, snorkeling, walking on uneven sandy beaches, stooping, exercising at a gym, bending and lying down in the sun for extended periods and getting up without any signs of dizziness.

[1] The physician's signature is illegible.

[2] The memoranda of activity noted that appellant was observed on August 8, 9, 21, 25, 26 and 27 and September 14, 2008. The video was in digital video disc (DVD) form.

Two agents interviewed appellant on September 18, 2008. Appellant described the May 31, 2008 accident and that she could not drive for two months thereafter. She had daily blurred vision and headaches. Appellant stated that she could not swim, access in and out of the car was difficult, and when she bent over or knelt, she felt nauseated as if she was going to pass out. She could only stand for 10 minutes before becoming dizzy and her activities were very limited, noting a recent visit to a resort for the day was her first trip since the employment injury. Appellant described memory lapses such as forgetting where she parked her car. She was informed that she had been watched and given the opportunity to set the record straight, replied that she did not care. Appellant signed an assessment form indicating that she felt her condition was improving somewhat with good days and bad and that her eyesight had worsened. She reiterated that her activities were limited compared to before the employment injury.

On September 22, 2008 the agents interviewed Dr. Farmer. They showed him highlights of the surveillance and provided him a questionnaire to complete. Dr. Farmer stated that appellant did not appear to have debilitating dizziness, vision problems or memory problems and based on her viewed activities she seemed able to perform similar duties at work, including her usual duties. He concluded, "it seems [appellant] has misrepresented her disability."

On November 13, 2008 the Office proposed to terminate appellant's monetary compensation on the grounds that the medical evidence established that she was able to perform her usual work duties. In a November 13, 2008 letter, it asked that Dr. Farmer review an attached statement of accepted facts and Dr. Drazin's report to address how the condition of postconcussive labyrinthitis affected the peripheral vestibular system and not the central vestibular system was related to the May 31, 2008 employment injury. In an undated response, Dr. Farmer advised that appellant was no longer seeking care from his office. He noted that central vestibular dysfunction would suggest brain injury and peripheral vestibular dysfunction would suggest injury to the vestibulocochlear nerve and/or the semicircular apparatus in the inner ear, which should resolve over the course of several weeks.

By decision dated December 15, 2008, the Office terminated wage-loss compensation. Appellant was informed that she was still entitled to medical benefits for the accepted condition.

On January 15, 2009 appellant requested that a hearing be held on May 14, 2009. She testified that she initially had difficulty finding a treating physician. Appellant still experienced headaches, nausea, blurred and double vision that came and went. She was told that she had a blind spot behind her right eye.

In a July 21, 2008 report, Dr. Gerald D. Carp, a Board-certified ophthalmologist, advised that eye examination was within normal limits. He diagnosed concussion syndrome from a motor vehicle accident on May 31, 2008 and status post prior refractive surgery. In a September 24, 2008 report, Dr. Farmer advised that she reported that she had improved significantly but the thought of returning to work created anxiety and crying and a more dramatic description of symptoms. He noted that appellant drove to his office unassisted and seemed able to carry out activities of daily living.

In a December 29, 2008 report, Dr. Kim Chi T. Nguyen, Board-certified in family medicine, noted that appellant was injured in May 2008 to the right side of her face. Appellant

had an overlap of visual field and a dent on the right side of her head with intermittent numbness of her face, dizziness, nausea and vertigo with occasional loss of bladder control and short-term memory problems. Dr. Nguyen provided physical examination findings, noting a slight lag in the right eye. He diagnosed vertigo, eye pain and neck pain. A December 29, 2008 x-ray of orbits was normal and a cervical spine x-ray that day demonstrated degenerative disc disease. By report dated December 30, 2008, Dr. Maria Decastro, an osteopath specializing in neurology, noted the history of injury and medical treatment as reported by appellant. She performed neurological examination and diagnosed probable postconcussion syndrome with symptoms of peripheral vestibulopathy causing positional vertigo, cervical strain and cervicogenic headaches.[3]

On December 31, 2008 Dr. William Bloedon, Board-certified in family medicine, advised that appellant stated that she was sick from December 29, 2008 and could not return to work until January 8, 2009. In a December 31, 2008 report, Dr. Laura S. Kearsley, an ophthalmologist, diagnosed monocular diplopia that could be due to refractive error and recommended refraction and new glasses. By report dated January 8, 2009, Dr. Sharita B. Abbott, Board-certified in family medicine, noted appellant's complaints of dizziness and vertigo for six months preceded by headache. She moved slowly and hesitantly, finger to nose examination was intact but slow and appellant had a mild decreased sensation over the right jaw. Dr. Abbott diagnosed peripheral vestibulopathy. A January 9, 2009 magnetic resonance imaging (MRI) scan of the brain was normal with an incidental six-millimeter cyst seen in the anterior right temporal lobe.

In a January 16, 2009 report, Dr. Nguyen advised that appellant sustained a head injury in May 2008, had vertigo and neck pain since that time and could not return to work. By report dated January 23, 2009, Dr. Daniel C. Schiessler, an optometrist, provided refractive findings and diagnosed presbyopia. On February 23, 2009 Dr. Alan S. Song, a Board-certified otolaryngologist, noted a history of vertigo. He reviewed the January 9, 2009 MRI scan findings, noted bilateral mild to moderate hearing loss on audiography and diagnosed post-traumatic vertigo. On March 23, 2009 Dr. Nguyen noted that occupational and physical therapy helped appellant and she felt much better but still had intermittent symptoms and increased confusion. The diagnosis was cognitive disorder. On March 24, 2009 Dr. Decastro stated that a neurological examination was normal. He advised that appellant had symptoms of anxiety and depression and recommended electroencelography and a sleep study. On April 19, 2009 Dr. Nguyen noted appellant's report of increased confusion. A May 11, 2009 sleep study demonstrated sleep talking, benign snoring and no sleep apnea or periodic limp movements.

By decision dated July 21, 2009, an Office hearing representative affirmed the December 15, 2008 decision.

[3] Dr. Decastro advised that speech was fluent with no dysarthria and that appellant was alert and oriented to time and place. Money calculation, naming, reading, writing, copying abstract figures, following three-step commands and repetition of sentences were intact and appellant could spell "table" backwards. The right pupil measured three millimeters, the left four millimeters and both were reactive to light. Papilledema was not seen and nystagmus not present. Light touch and pinprick were decreased over the right jaw with no facial weakness. Muscle tone and strength were normal and symmetric in all four extremities and sensory examination demonstrated decreased pinprick, light touch, temperature, vibration over right side. Finger to nose, heel to shin and rapid alternating movements were normal with a negative Romberg negative. Gait and tandem walk were normal with no tremors.

LEGAL PRECEDENT

Once the Office accepts a claim and pays compensation, it has the burden of justifying modification or termination of an employee's benefits. It may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.[4] The Office's burden of proof in terminating compensation includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[5]

ANALYSIS

The Board finds that the Office met its burden of proof to terminate appellant's monetary compensation on December 15, 2008. The Office accepted that on May 31, 2008 appellant sustained a right forehead laceration, without complications, when she struck her head while backing her postal vehicle. Appellant did not return to work and received wage-loss compensation. On December 15, 2008 the Office terminated her benefits finding that the medical evidence established that she could return to her regular duties.

The Board finds that the weight of medical opinion rests with Dr. Farmer, the attending osteopath, who treated appellant following the injury and found that she could return to work as of July 7, 2008. While Dr. Farmer subsequently advised that she should not work due to increasing symptoms of double vision, vertigo and memory loss, he subsequently advised that she did not appear to have any debilitating dizziness, vision problems or memory problems after viewing the surveillance videotape. He found appellant was able to perform her usual job without residuals. Appellant has alleged continuing total disability due to multiple diagnoses, but these other conditions have not been accepted as caused by the May 31, 2008 employment incident. Other than the accepted facial laceration it is her burden of proof to establish causal relation.[6]

The weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.[7] The opinion of an attending physician is entitled to great weight.[8] The Board finds that the weight of the medical evidence rests with the opinion of Dr. Farmer who found that she could perform her usual job duties. The Office met its burden of proof to terminate appellant's monetary compensation on December 15, 2008.[9]

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[4] *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[5] *Id.*

[6] *Alice J. Tysinger*, 51 ECAB 638 (2000).

[7] *C.B.*, 60 ECAB ___ (Docket No. 08-1583, issued December 9, 2008).

[8] *See William J. Mallon*, 19 ECAB 560 (1968); *Dorothy D. Kroening*, 12 ECAB 16 (1960).

[9] The Board notes that appellant's attorney was furnished a copy of the DVD and investigative report. No comments were received concerning either. *See J.M.*, 58 ECAB 478 (2007) and cases cited therein.

Regarding appellant's argument on appeal, there is no evidence to support the assertion that Dr. Farmer was pressured by federal agents. Dr. Farmer did not complain that he was coerced or express any reservations about the materials he was asked to review. On September 22, 2008 inspector general agents interviewed Dr. Farmer. They provided the attending physician highlights of video surveillance and a questionnaire to complete. In answer to specific questions, Dr. Farmer stated that appellant did not appear to have any debilitating dizziness, vision problems or memory problems. Based on the activities viewed on the videotape, appellant could perform similar duties at work, including her usual duties. Dr. Farmer noted that it seemed appellant misrepresented her disability. By report dated September 24, 2008, he noted that appellant drove to his office unassisted and able to carry out activities of daily living. Dr. Farmer subsequently advised that she no longer sought care from his office. He advised that a peripheral vestibular dysfunction would suggest injury to the vestibulocochlear nerve and/or the semicircular apparatus in the inner ear which should resolve over the course of several weeks.

The remaining medical evidence is not relevant to whether the Office properly terminated her monetary compensation on December 15, 2008. As noted, the only accepted condition was a forehead laceration. Dr. Drazin did not comment on appellant's ability to work and in his September 18, 2008 report noted only that her symptoms of vestibulopathy were resolving. Dr. Kearsley advised that appellant's double vision could be due to a refractive error and recommended new glasses. Dr. Schiessler, who provided refractive findings, diagnosed presbyopia. None of the physicians addressed the accepted laceration as a cause of continuing disability. Drs. Decastro, Abbot and Song did not comment on appellant's ability to work. Dr. Bloedon merely stated that appellant advised that she was sick from December 29, 2008 and could not return to work until January 8, 2009. He did not provide any diagnosis or medical opinion concerning her disability for work. When a physician's statements regarding an employee's ability to work consist only of repetition of the employee's complaints that she hurt too much or was too sick to work, without objective findings of disability being shown, such opinion is of reduced probative value.[10]

Dr. Nguyen advised on January 16, 2009 that appellant could not work due to vertigo and neck pain since a May 2008 head injury. On April 2009 appellant had cognitive changes and headaches. Again, none of these conditions were ever accepted as employment related.[11] Dr. Nguyen did not explain how the injury of May 3, 2008 caused these conditions, or provide an accurate history of appellant's job duties. Her opinion on causal relationship between a claimant's disability and an employment injury is not dispositive simply because it is rendered by a physician. To be of probative value, Dr. Nguyen must provide rationale for the opinion reached. Where no such rationale is present, the medical opinion is of diminished probative value.[12] Based on the evidence of record, Dr. Farmer's opinion that appellant could return to regular duty constitutes the weight of medical evidence. Thus, the Office properly terminated appellant's monetary compensation.

[10] *S.F.*, 59 ECAB 525 (2008).

[11] *Alice J. Tysinger, supra* note 6.

[12] *Thaddeus J. Spevack*, 53 ECAB 474 (2002).

CONCLUSION

The Board finds that the Office met its burden of proof to terminate appellant's monetary compensation on December 15, 2008.

ORDER

IT IS HEREBY ORDERED THAT the July 21, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 25, 2011
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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