United States Department of Labor
Employees' Compensation Appeals Board

J.K., Appellant	)	
and	)	**Docket No. 10-1059**
	)	**Issued: January 13, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Chicago, IL, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 8, 2010 appellant filed a timely appeal from the Office of Workers' Compensation Programs' merit decision of November 17, 2009 which terminated his compensation 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 properly terminated appellant's monetary and medical benefits effective July 10, 2009.

FACTUAL HISTORY

On February 1, 2005 appellant, then a 48-year-old substitute clerk, injured his left arm and neck after pulling and keying mail. He stopped work on January 31, 2005 and returned on February 3, 2005. The Office accepted the claim for displacement of a cervical intervertebral disc, lumbago, cervicalgia, aggravation of spinal stenosis and osteoarthritis of the spine. Appellant was again off work from April 28, 2005 though January 13, 2006. He returned to full

duty on January 14, 2006 and stopped work on April 13, 2006. Appellant returned to full-time limited duty on July 25, 2006 and stopped work completely on August 4, 2006. The Office subsequently accepted lumbago and lumbar spinal stenosis and authorized a May 22, 2007, lumbar disc decompression at L4-5, performed by his treating physician, Dr. Bruce Montella, a Board-certified orthopedic surgeon. Appellant was placed on the periodic rolls in receipt of monetary benefits.

In an October 5, 2007 report, Dr. Montella related that appellant had ongoing difficulties with low back and radiating leg pain and opined that his symptoms "were consistent with a recurrent lumbar disc herniations." He recommended a repeat magnetic resonance imaging (MRI) scan.

An October 16, 2007 electromyogram, read by Dr. Vipan Gupta, a Board-certified neurologist, was normal in the tested muscles of the arms.

On October 17, 2007 the Office referred appellant to Dr. Hythem P. Shadid, a Board-certified orthopedic surgeon, for a second opinion examination to determine appellant's current status and work capacity.

In a November 14, 2007 report, Dr. Montella diagnosed lumbar disc herniation and thoracic disc injury. He noted that appellant's condition was unchanged. Dr. Montella opined that it was unreasonable for him to participate at work in any way.

In a December 3, 2007 report, Dr. Shadid reviewed appellant's history of injury and treatment. He noted that appellant's motor and sensory examinations were fully intact in both lower extremities with normal strength in flexion, extension, abduction and adduction. The lumbar spine was basically normal with significant pain to palpation over the left sacroiliac joint. The cervical spine showed some restricted mobility; however, Dr. Shadid opined that it was "difficult to assess how much of this is effort related." He diagnosed cervical spinal stenosis, congenital, lumbar degenerative spondylosis and sacroilitis. Dr. Shadid found no current evidence of ongoing cervicalgia. He opined that any aggravation of the spinal stenosis and osteoarthritis was no longer active. The aggravation of these preexisting conditions ceased in March 2005 for the diagnosis of cervical spinal stenosis and on July 25, 2006 for the osteoarthritis of the spine. Dr. Shadid explained that there was no evidence of any material change or alteration to the cervical or lumbar spines that would have worsened appellant's condition. The findings from the MRI scans were not causally related to the accepted conditions other than documentary preexisting osteoarthritis being aggravated temporarily. Dr. Shadid advised that appellant was unable to perform his date-of-injury job due to preexisting cervical spine stenosis and degenerative sacroilitis; but appellant was able to work eight hours a day with restrictions on certain activities. He advised that no further medical treatment was indicated.

A January 29, 2008 MRI scan of the lumbar spine, read by Dr. Gregory Adamo, a Board-certified diagnostic radiologist, revealed degenerative changes with central disc protrusion at L4-5 with a mild degree of spinal stenosis. Degenerative changes were also seen at L3-L4 with bulging of disc material and minor spinal stenosis.

In a letter dated February 20, 2008, the Office provided Dr. Montella with a copy of Dr. Shadid's report. In a February 28, 2008 report, Dr. Montella noted that, since appellant's injury at work, he experienced back and radiating leg pain consistent with discogenic disorder. He advised that appellant was a candidate for decompression fusion surgery. Dr. Montella noted that appellant wished to proceed with epidural steroid injections to help resolve his condition. He opined that it was unreasonable for appellant to work in any way.

On January 9, 2009 the Office referred appellant, together with a statement of accepted facts and the medical record to Dr. Jaroslaw B. Dzwinyk, a Board-certified orthopedic surgeon, for an impartial medical evaluation to resolve a conflict in medical opinion between Drs. Montella and Shadid regarding appellant's disability status and work restrictions.

In a February 2, 2009 report, Dr. Dzwinyk noted appellant's history of injury and medical treatment. Appellant exhibited no pain behaviors during the examination, but there were "nonorganic responses" during the course of the evaluation. Dr. Dzwinyk noted findings of positive Waddell signs, normal gait and a voluntarily restricted range of motion of the cervical and lumbar spine. Appellant's reflexes and strength were normal. Dr. Dzwinyk determined that appellant had decreased sensation to light touch over the left small finger, the lower extremities, medial left foot and medial and lateral aspects of the lower leg in a nonanatomic distribution. Straight leg raising was negative while seated but it elicited low back pain in the supine position. Dr. Dzwinyk advised that appellant had undergone MRI scans of the cervical spine and left shoulder but the results were unavailable to him. He noted that cervicalgia was a symptom and not a diagnosis as it referred generally to neck pain. Dr. Dzwinyk advised that there was no support for appellant's symptoms of neck and left arm pain based on a normal electromyography (EMG) scan and nerve conduction studies (NCS) and minimally abnormal cervical MRI scan, none of which substantiate an injury. Similarly, lumbago referred to low back pain. The conditions of aggravation of lumbar stenosis and osteoarthritis of the spine were found no longer active. There was no evidence of significant lumbar stenosis on diagnostic testing and appellant's symptoms did not suggest stenosis. While there may have been an aggravation of osteoarthritis of the lumbar spine early in the course of treatment, since aggravation had since resolved given that nearly four years passed since the original injury. Dr. Dzwinyk found that appellant's current symptoms could be attributed to his preexisting cervical and lumbar degenerative disc disease, which was unrelated to any specific work injury or cumulative injury due to work activities. While appellant was incapable of performing his previous job duties, Dr. Dzwinyk advised that this was due to the preexisting cervical and lumbar degenerative disc disease. He provided an accompanying work restriction evaluation form noting appellant's work restrictions.

On March 2, 2009 Dr. Montella administered lumbar epidural steroid injections. In an April 16, 2009 report, he diagnosed lumbar disc herniation and left shoulder impingement. Dr. Montella noted that appellant had a lot of difficulties with activity-related pain referable to appellant's back and shoulder. Appellant's condition was consistent with work-related lumbar disc herniation and left shoulder impingement. Dr. Montella advised that appellant's physical examination was unchanged and that he remained totally disabled. A February 20, 2009, left shoulder MRI scan from Dr. George G. Kuritza, a Board-certified diagnostic radiologist, revealed mild inflammatory fluid surrounding the distal supraspinatus portion of the rotator cuff tendon, probably tendinitis and/or bursitis.

On May 1, 2009 the Office proposed to terminate appellant's compensation benefits based on the opinion of Dr. Dzwinyk who found that the January 28, 2005 work injury had ceased without residents.

On May 5, 2009 the Office submitted the February 20, 2009 MRI scan of the left shoulder to Dr. Dzwinyk, for review. In a June 15, 2009 response, Dr. Dzwinyk advised that the diagnostic test and medical records did not change the findings listed in his report of February 2, 2009.

In a July 10, 2009, decision, the Office terminated appellant's compensation benefits effective that date.

On August 5, 2009 appellant requested a review of the written record. On June 18, 2009 Dr. Montella reiterated that appellant's injuries were severe and debilitating and that the current examination and diagnostic findings were consistent with his work-related diagnoses. He diagnosed cervicalgia and advised that it was a symptom of cervical disc herniation with radiculopathy. The fact that appellant's diagnostic studies were normal meant that they needed to be repeated. Dr. Montella advised that status tests "are known to be insensitive early in the clinical course but become more helpful as time goes by. We are going to go ahead and repeat that. Minimally, abnormal cervical MRI scanning findings is supportive of his diagnosis of cervical disc pathology and radiculopathy. They both substantiate an injury." Appellant's lumbar disc herniation led to lumbago that was work related and consistent with objective findings. Dr. Montella related that appellant's symptoms were aggravated by bending and sitting. On examination, he noted limited lumbar range of motion, tenderness to deep palpation, no signs of incongruency, as well as x-ray and MRI scan results consistent with a lumbar disc herniation. Dr. Montella opined that appellant's current symptoms could not be explained on the basis of the preexisting cervical or lumbar degenerative disc disease. He stated that degenerative changes were consistent with the normal process of aging and did not cause symptoms but a person susceptible to the onset of symptoms. Such onset required an "injury and in this case it came on as a direct result of [appellant's] participation at work." Dr. Montella opined that appellant was totally disabled. Subsequent treatment notes reiterated the findings of total disability.

In a November 17, 2009 decision, an Office hearing representative affirmed the July 10, 2009 decision. She found that the report of Dr. Dzwinyk, the impartial medical examiner, was entitled to special weight and established that appellant no longer had residuals of the accepted cervical and lumbar conditions.

LEGAL PRECEDENT

Once the Office accepts a claim and pays compensation, it bears the burden to justify modification or termination of benefits.[1] Having determined that an employee has a disability causally related to his or her federal employment, the Office may not terminate compensation

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

without establishing either that the disability has ceased or that it is no longer related to the employment.[2]

The Federal Employees' Compensation Act[3] 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.[4] 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.[5]

ANALYSIS

The Office determined that a conflict of medical opinion arose regarding the nature and extent of disability and ongoing residuals of the work injury of February 1, 2005. Dr. Montella, appellant's physician and a Board-certified orthopedic surgeon, supported total disability as while Dr. Shadid, a Board-certified orthopedic surgeon and second opinion physician, as these two physicians disagreed as to whether appellant continued to have work-related residuals and disability, the Office properly referred appellant to Dr. Dzwinyk for an impartial examination.

The Board finds that Dr. Dzwinyk's February 2, 2009 report is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight in establishing that disability due to residuals of appellant's accepted conditions had ceased. Dr. Dzwinyk, provided an extensive review of appellant's history, reported examination findings and determined that there were no objective findings to correspond with appellant's subjective complaints. He found no objective evidence of work-related disability. Dr. Dzwinyk noted that appellant did not exhibit any pain behavior during the examination but there were "nonorganic responses" such as a voluntarily restricted range of motion of the cervical and lumbar spine. He found that appellant had a normal EMG/NCV and minimally abnormal cervical MRI scan and advised that neither of these findings substantiated residuals related to the accepted conditions. Dr. Dzwinyk determined that there was no evidence of significant lumbar stenosis on current diagnostic testing. He opined that the aggravation of osteoarthritis of the lumbar spine had resolved nearly four years passed since the time of the original injury. Dr. Dzwinyk explained that appellant's current symptoms were due to his underlying cervical and lumbar degenerative disc disease that was unrelated to a specific work injury or a cumulative injury from work activities. He opined that appellant's inability to perform his previous job duties was due to the preexisting cervical and lumbar degenerative disc disease. Dr. Dzwinyk noted that appellant was capable of working with restrictions.

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

[3] 5 U.S.C. §§ 8101-8193, 8123(a).

[4] 5 U.S.C. § 8123(a); *Shirley Steib,* 46 ECAB 309, 317 (1994).

[5] *Gary R. Sieber,* 46 ECAB 215, 225 (1994).

On May 5, 2009 the Office provided Dr. Dzwinyk with a copy of a February 20, 2009 MRI scan and requested his opinion in light of the new records since his last report. In a June 15, 2009 response, Dr. Dzwinyk responded that his opinion remained unchanged.[6] The Board finds that the Office properly accorded special weight to the impartial medical examiner's opinion whose opinion represents the weight of the medical evidence and establishes that work-related disability and residuals of the accepted conditions had resolved.[7]

Subsequent to the evaluation by Dr. Dzwinyk, the Office received additional reports from Dr. Montella that generally reiterated previously stated findings about appellant's condition. In his June 18, 2009 report, Dr. Montella repeated his opinion that appellant's injuries were severe and debilitating and that he was unable to work. Although he noted that appellant's EMG/NCV was normal, he indicated that this meant it "needed to be repeated" asserting that such tests "are known to be insensitive early in the clinical course but become more helpful as time goes by" and that "minimally abnormal cervical MRI scanning findings is supportive of his diagnosis of cervical disc pathology and radiculopathy." However, Dr. Montella did not provide any supporting rationale to explain how he came to the conclusion that negative diagnostic testing was erroneous and why any diagnosed condition was employment related. Without medical rationale to explain the basis of his conclusion, his opinion is of limited probative value.[8] Likewise, Dr. Montella did not provide sufficient medical reasoning to explain how he determined that current symptoms were not due to the preexisting conditions and that degenerative changes did not cause symptoms. In any event, the Board has held that reports from a physician who was on one side of a medical conflict that an impartial specialist resolved, are generally insufficient to overcome the weight accorded to the report of the impartial medical examiner or to create a new conflict. Thus, the medical evidence appellant submitted was insufficient to overcome the weight accorded to the impartial medical specialist or create a new conflict with that of Dr. Dzwinyk.

On appeal, appellant submitted additional evidence. However, the Board has no jurisdiction to review this evidence for the first time on appeal.[9]

CONCLUSION

The Board finds that the Office met its burden of proof in terminating appellant's benefits effective July 10, 2009.

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[6] When the Office obtains an opinion from an impartial medical specialist for the purpose of resolving a conflict in the medical evidence and the specialist's opinion requires clarification or elaboration, it must secure a supplemental report from the specialist to correct the defect in his original report. *See Talmadge Miller*, 47 ECAB 673 (1996); *Harold Travis*, 30 ECAB 1071, 1078 (1979).

[7] *See supra* note 5.

[8] *See George Randolph Taylor*, 6 ECAB 986, 988 (1954) (where the Board found that a medical opinion not fortified by medical rationale is of little probative value).

[9] 20 C.F.R. § 501.2(c); *James C. Campbell,* 5 ECAB 35 (1952). This decision does not preclude appellant from seeking to have the Office consider such evidence pursuant to a reconsideration request filed with the Office.

ORDER

IT IS HEREBY ORDERED THAT the November 17, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 13, 2011
Washington, DC

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

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

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