United States Department of Labor
Employees' Compensation Appeals Board

M.A., Appellant	)	
and	)	**Docket No. 10-1814**
	)	**Issued: May 11, 2011**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Cleveland, OH, 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 July 1, 2010 appellant filed a timely appeal from the February 24, 2010 merit decision of an Office of Workers' Compensation Programs' hearing representative who affirmed the termination of her compensation benefits. Pursuant to the Federal Employees' Compensation Act,[1] and 20 C.F.R. §§ 501.2(c) and 501.3 the Board has jurisdiction to consider the merits of the appeal.

ISSUE

The issue is whether the Office met its burden of proof to terminate appellant's compensation benefits as of June 25, 2009 on the basis that she had no disabling residuals related to her June 17 or December 12, 1976 employment injuries.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On June 17, 1976 appellant, then a 22-year-old nursing assistant, sustained a lumbosacral strain when she fell to the floor while transferring a patient to a toilet. She sustained a second lumbar strain on December 12, 1976 while adjusting a patient in bed.[2] Appellant stopped work on December 6, 1977 and claimed a recurrence of disability. She did not return to work. The Office accepted acute lumbar strains and a psychogenic pain disorder.[3] Appellant was placed on the periodic rolls in receipt of compensation for total disability.[4]

Appellant was treated by Dr. Nicholas J. Kavoklis, an osteopathic family practitioner, for her back condition and by Dr. Doris El-Tawil, Ph.D., a clinical psychologist, for her emotional condition. Dr. Kavoklis treated appellant conservatively with epidural injections, physical modalities and recommended exercise. Dr. El-Tawil provided psychotherapy counseling and relaxation techniques.[5] On October 23, 1991 a lumbar spine computerized tomography scan was obtained that showed a small posterior herniation of L5-S1 favoring the right side impressing on the thecal sac but not visibly compressing nerve roots.[6]

Appellant was referred by the Office to Dr. Sheldon Kaffen, a Board-certified orthopedic surgeon, for an updated medical examination and opinion regarding her accepted low back condition. In an October 13, 2004 report, Dr. Kaffen reviewed a history of appellant's injuries at work in 1976 and subsequent medical treatment. He noted that she continued to see her physician approximately every month and her treatment consisted of the application of heat, medication and an exercise program. Dr. Kaffen provided findings on examination of appellant's low back, noting that she complained of brief shooting pains to both lower extremities. There was tenderness in the midline of the lumbar region with a marked degree of muscle guarding present. Straight leg raising was negative in both the sitting and supine

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[2] Appellant received continuation of pay from June 18 to August 2, 1976. She returned to work on September 21, 1976. Following the second injury, appellant again received continuation of pay and returned to duty as of January 2, 1977.

[3] The Office accepted psychogenic pain disorder based on the September 31, 1981 referral report of Dr. Norman L. Roulet, a Board-certified psychiatrist, who noted that appellant's condition "should be a temporary disability, but the degree of secondary gain that [appellant] is receiving from various sources could make it a permanent one."

[4] Diagnostic testing on April 13, 1981 of the lumbosacral spine showed normal vertebral bodies and preserved interspaces with no evidence of fractures or arthritis. The sacroiliac joints were reported as normal with spina bifida occulata noted at T12-L1. A May 31, 1984 x-ray reported no abnormalities other than the spina bifida occulata with a congenital absence of the spinous process at these levels.

[5] Appellant was referred for psychiatric evaluation by the employing establishment. On March 29, 1983 Dr. Joel S. Steinberg, a Board-certified psychiatrist, diagnosed a passive-dependent personality preexisting the employment injuries that was temporarily aggravated and had ceased. He advised that she had no continuing psychiatric disability.

[6] On November 22, 1991 appellant filed an appeal to the Board in Docket No. 92-401 from decisions of the Office finding that she did not timely file a claim for carpal tunnel syndrome. By order dated August 28, 1992, the case was remanded for consolidation with appellant's current back injury claim. The claim for carpal tunnel was not accepted as related to the 1976 injuries.

positions with neurologic findings of bilateral and equal deep tendon reflexes. There was no muscle atrophy. Dr. Kaffen reviewed the medical record and noted mild degenerative disc disease at L5-S1 with narrowing of the disc space at L4-5 and T11-12. He noted that appellant had not worked since the time of injury and that a spinal surgeon had recommended a spinal fusion to treat the degeneration at L4-5 and L5-S1. In response to questions posed by the Office, Dr. Kaffen found that appellant no longer had residuals of the lumbar injuries accepted for sprain/strain. He stated that her accepted conditions had resolved and that her current back complaints were not caused by the 1976 injuries but were attributable to her underlying degenerative disc disease and facet arthritis. Dr. Kaffen advised that had the injuries not occurred, the underlying preexisting degenerative disease would have progressed to this point through the natural aging process. He stated that appellant's degenerative disease was not aggravated by the accepted lumbar strains, as the x-rays of record established this condition was not present at the time of injury. Dr. Kaffen also advised that her recommended surgery was not related to the 1976 back injuries at work. He found that appellant was unable of performing her regular duties as a nursing assistant due to her underlying lumbar spine degenerative disease and left foraminal stenosis at L5 and that no further medical treatment was warranted for the accepted conditions. Dr. Kaffen noted that appellant also had an accepted psychogenic pain disorder that was outside the area of his expertise to address.

The Office found a conflict in medical opinion between Dr. Kavoklis and Dr. Kaffen on whether appellant had any disabling residuals of her accepted lumbar strain. To resolve the conflict, it referred appellant to Dr. Robert H. Anschuetz, a Board-certified orthopedic surgeon, for an impartial medical examination. In a July 16, 2007 report, Dr. Anschuetz reviewed appellant's history of injury, medical treatment and a statement of accepted facts. He noted that appellant complained of ongoing severe low back pain. On examination, Dr. Anschuetz noted paraspinous muscle spasm bilaterally and neither sciatic notch was tender to palpation. Deep tendon reflexes were present bilaterally and sensory examination led to complaint of diminished sensation over the entire left leg. Straight leg raising led to complaint of left-sided low back pain and right leg radicular pain. On review of the diagnostic studies, Dr. Anschuetz noted degenerative findings and found facet arthritis. He advised that he found no evidence of ongoing lumbar sprain/strain, opined that the accepted lumbar condition had resolved and there was no residual disability preventing appellant from working as a nursing assistant. Dr. Anschuetz stated that it was appellant's lumbar degenerative disease arthritis and lumbar instability that precluded her return to full-time employment. He noted that his recommended work restrictions were not the result of residuals of her accepted work injuries but due to the underlying degenerative pathology.

Appellant submitted the periodic treatment notes of Dr. Susan E. Stephens, an orthopedic surgeon.[7] On September 14, 2007 she examined appellant and noted a history of low back pain with radiculopathy. Appellant related that she took no medication over the prior eight months and complained of low back pain radiating down the right leg more than the left. Dr. Stephens listed the allowed diagnosis of lumbosacral sprain and recommended diagnostic studies. On September 21, 2007 a magnetic resonance imaging scan was obtained of the lumbar spine which reported the lumbar vertebral discs in normal configuration with no evidence of fracture or

[7] Following the retirement of Dr. Kavoklis, the Office authorized appellant's treatment by Dr. Susan E. Stephens.

marrow disease. The conus and cauda equine were normal in appearance. The disc spaces at L1-2, L2-3 and L3-4 were described as normal with mild disc dehydration at L4-5 and disc space narrowing. There was a Grade 1 anterior spondylolisthesis of L4 on L5 with bulging of the disc and facet hypertrophy and moderate left sided foraminal stenosis. The canal diameter was described as adequate. At L5-S1 there was dehydration and disc narrowing but no mass effect on the thecal sac or S1 nerve roots. There was moderate bilateral foraminal stenosis with crowding of the L5 nerve roots.[8]

Appellant was also referred for an updated psychiatric evaluation to Dr. Bharat J. Shah, Board-certified in psychiatry. In an October 31, 2007 report, Dr. Shah addressed his examination of appellant and reviewed her prior occupational and family history. On mental status examination, he noted that appellant was alert, oriented to time, place and person with normal speech. Dr. Shah found that her mood was mildly depressed but her concentration was good. There were no hallucinations or delusions noted or signs of impulsivity. Dr. Shah diagnosed a depressive disorder, not otherwise specified under Axis 1 and advised that she was coherent and logical during examination and showed good exercise of judgment. He stated: "In clinical correlation with her diagnosis of psychogenic pain disorder (now a new terminology, pain disorder associated with psychological factors) she should have significant severity of pain, which was not seen during the interview. Pain has not caused impairment in her social functioning." Dr. Shah noted that psychological factors were not important in the onset or severity of appellant's condition and that it was difficult to decide whether her symptoms were from some fictitious disorder of malingering. He deferred any diagnostic studies involving appellant's low back to physicians specializing in such disorders. Dr. Shah concluded that appellant did not have any significant psychological factors causing stress in her life but noted she had commented on some past accidents and failed marriages. He found that her psychogenic pain disorder had resolved. Based on the psychiatric evaluation, Dr. Shaw concluded that appellant was capable of working her date-of-injury job as a nursing assistant. In supplemental reports of December 14, 2007 and June 6, 2008, he reiterated that appellant's accepted psychogenic pain disorder had resolved without residual disability and that her ongoing depressive condition was due to the accepted injuries of 1976.

On May 11, 2009 the Office advised appellant that it proposed to terminate her compensation benefits. It noted that her claim had been accepted for lumbar strains arising from the 1976 employment injuries and a psychogenic pain disorder. The Office found that the weight of medical opinion as to appellant's lumbar condition was represented by the report of Dr. Anschuetz, the impartial medical specialist, who advised that the accepted strains had resolved. As to her psychiatric condition, it found that Dr. Shah determined that the accepted psychogenic pain disorder had resolved without residual. Appellant was advised of the

[8] On November 2, 2007 Dr. Stephens noted that she would try to get allowance for the additional diagnosis of aggravation of preexisting condition. By letter dated December 12, 2007, the Office advised Dr. Stephens that there was no medical basis for accepting spondylolisthesis or lumbar canal stenosis. It provided her with copies of the reports of Dr. Kaffen and Dr. Anschuetz.

opportunity to submit additional evidence if she disagreed with the proposed action. She did not respond.[9]

In a June 25, 2009 decision, the Office terminated appellant's compensation benefits effective that day. It found that she no longer had any disability or residuals of the accepted lumbar or psychological conditions.

On July 2, 2009 appellant requested an oral hearing before an Office hearing representative. A hearing was held on December 2, 2009 at which she appeared and addressed her injuries and medical treatment. Appellant noted recently receiving treatment for her psychological condition and low back.

Appellant submitted counseling treatment records dated June 18 to September 29, 2009 from Felicia C. Hameed, a licensed social worker. She was diagnosed with a depressive disorder. In a December 2, 2009 letter, Ms. Hameed advised that appellant was being seen for psychotherapy and medication. It was noted that appellant "feels she is unable to work at this time due to her multiple medical and psychiatric conditions."

In a February 24, 2010 decision, an Office hearing representative affirmed the June 25, 2009 termination decision. She found that the weight of medical evidence established that appellant's accepted lumbar strains and psychogenic pain disorder had resolved without any residual disability.

LEGAL PRECEDENT

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation benefits.[10] It may not terminate compensation without establishing that the disability ceased or that it is no longer related to the employment.[11] The Office's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[12] 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 a claimant no longer has residuals of an employment-related condition that require further medical treatment.

Section 8123(a) of the Act provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[13] When the case is referred to an

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[9] The Office received several medical reports pertaining to appellant's referral by Dr. Stephens to Dr. Timothy A. Moore and Dr. Jacob R. Bosley for consultation. X-rays were obtained on June 4, 2009 that showed moderate degenerative changes most notable at L5-S1.

[10] *I.J.,* 59 ECAB 408 (2008).

[11] *J.M.,* 58 ECAB 478 (2007).

[12] *Id.*; *see also Anna M. Blaine,* 26 ECAB 351 (1975).

[13] *Id.* at § 8123(a). *See Elsie L. Price*, 54 ECAB 734 (2003); *Raymond J. Brown*, 52 ECAB 192 (2001).

impartial medical specialist for the purpose of resolving a conflict in medical evidence, the opinion of such specialist will be given special weight when based on a proper factual and medical background and sufficiently well rationalized on the issue presented.[14]

ANALYSIS

Appellant's claims were accepted by the Office for lumbar strains sustained on June 17 and December 12, 1976 while moving patients in the performance of duty. It also accepted that she sustained a psychogenic pain disorder as a consequence of her employment injuries. Appellant stopped work on December 7, 1977 and was placed on the periodic rolls in receipt of compensation for total disability. The Board notes that at the time of injury, appellant had a preexisting genetic spinal disorder of spina bifida occulata at T12-L1.

The Office properly found a conflict in medical opinion as to appellant's ongoing disability and its relationship to her accepted injuries between Dr. Kavoklis, an attending family practitioner, and Dr. Kaffen, a Board-certified orthopedic surgeon and Office referral examiner. Dr. Kavoklis found that appellant was disabled due to residuals of her accepted back condition. Dr. Kaffen provided findings on examination and found that she no longer had residuals of the accepted lumbar strains; rather, he attributed her ongoing back symptoms and disability to underlying degenerative disease of the spine and facet arthritis. He commented that appellant's spinal condition would have developed had the employment injuries not occurred.

Appellant was referred for an impartial medical examination to Dr. Anschuetz, a Board-certified orthopedic surgeon, who was provided with a statement of accepted facts and reviewed the medical evidence of record. Dr. Anschuetz listed findings on examination of appellant, noting that he found no evidence to support any ongoing lumbar strain or sprain related to the accepted injuries. He determined that the accepted lumbar condition had resolved and attributed appellant's ongoing low back complaints to lumbar degenerative arthritis and lumbar instability that was unrelated to the 1976 work injuries. Dr. Anschuetz advised that appellant was not restricted from performing her former duties as a nursing assistant by the employment injuries, but that her underlying lumbar spine arthritis pathology and instability precluded her return to work.

The Board has held that in situations where a case is referred to an impartial medical specialist for the purpose of resolving a conflict in medical evidence, the opinion of such specialist is entitled to special weight when based on an accurate factual and medical background and a rationalized medical opinion addressing the questions directed by the Office.[15] The Board finds that the opinion of Dr. Anschuetz, a Board-certified orthopedic surgeon, is well rationalized and based upon a proper factual and medical history. Based on his review of the record and examination of appellant, the impartial medical specialist accurately summarized the relevant evidence and provided reasons for finding that appellant's accepted lumbar strains had resolved. Dr. Anschuetz detailed aspects of his examination that revealed underlying degenerative arthritic pathology of appellant's lumbar spine that he found responsible for her ongoing complaints and

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[14] *See Bernadine P. Taylor*, 54 ECAB 342 (2003); *Anna M. Delaney*, 53 ECAB 384 (2002).

[15] *See Kathryn E. DeMarsh*, 56 ECAB 677 (2005); *Mary Poller*, 55 ECAB 483 (2004).

incapacity for work. He noted that appellant's degenerative lumbar disease was progressive and would have resulted in her condition absent the soft tissue injuries accepted in 1976. The Board finds that the opinion of Dr. Anschuetz constitutes the special weight of medical evidence and was sufficient to sustain the Office's burden in terminating appellant's compensation based on the accepted lumbar injuries.

Appellant submitted additional reports from Dr. Stephens, an orthopedic surgeon and attending physician. The Board notes that the treatment records of Dr. Stephens did not set forth a full or accurate history of the injuries accepted in this case. Dr. Stephens did not provide a medical narrative addressing how the soft tissue injury strains sustained in 1976 would cause or contribute to the conditions of lumbar spondylolisthesis or facet arthritis she diagnosed in September 2007. Such a history is important in this case, as the medical evidence documents that appellant has a genetic disorder of the spine which was not addressed in the treatment notes from Dr. Stephens. As such, Dr. Stephens' records are insufficient to overcome the special weight accorded to the opinion of Dr. Anschuetz or to create a new conflict in medical opinion on appellant's lumbar condition.

As to appellant's accepted psychogenic pain disorder, the Board finds that the weight of medical opinion is represented by Dr. Shah, a Board-certified psychiatrist. At the time of the Office's referral in 2007, it noted that there had not been any recent treatment records submitted addressing this accepted condition. The Office provided Dr. Shah with a statement of accepted facts and the medical records. On October 31, 2007 Dr. Shah reviewed appellant's family and occupational background and reported findings on mental status examination. He found appellant to be alert, oriented as to time, place and person but noted symptoms of mild depression. Dr. Shah advised that appellant did not suffer from delusions or hallucinations or show signs of impulsivity. He diagnosed a depressive disorder, not otherwise specified. Dr. Shah explained that appellant did not exhibit symptoms of severe pain during his evaluation that would support the accepted pain disorder diagnosis. Of those he did address, he noted that it was difficult to tell whether they were fictitious or signs of malingering. Dr. Shah found that appellant's accepted psychogenic pain disorder condition had resolved and that, from a psychological standpoint, she was capable of returning to her date-of-injury job as a nursing assistant. He subsequently clarified that appellant's ongoing mild depressive symptoms were not related to the injuries of 1976.

The Board has held that in assessing medical evidence, the weight of a physician's opinion is determined by the opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts and medical history and the care of analysis manifested in the rationale expressed in support of the physician's opinion on causal relation.[16] Other factors that may bear on the weight accorded medical opinion include whether the physician is a specialist in the relevant field of medicine.[17] The Board finds that the weight of medical evidence as to appellant's psychogenic pain disorder is represented by the opinion of Dr. Shah who is a physician specializing in the relevant field of psychiatry. Dr. Shah provided reports to the Office that addressed her accepted condition with accuracy and reference to the

[16] *See Michael S. Mina*, 57 ECAB379 (2006); *John D. Jackson*, 55 ECAB 465 (2004).

[17] *See Beverly A. Spencer*, 55 ECAB 501 (2004).

statement of accepted facts. He had the opportunity to examine appellant and explained the basis for his conclusion that she was no longer disabled or had residuals of the accepted pain disorder condition. Dr. Shah found her to be alert, appropriately oriented and without any evidence for delusions or hallucinations. He explained that appellant did not demonstrate severe pain symptoms that would warrant a pain disorder diagnosis. Rather, Dr. Shah advised that she had symptoms of mild depression, a condition he found unrelated to the 1976 low back strain injuries. Based on his reports, the Office properly terminated appellant's compensation for the accepted condition of psychogenic pain disorder.

Appellant submitted treatment records pertaining to counseling sessions by Ms. Hameed, a licensed social worker, for a diagnosed depressive disorder. The Board notes that Ms. Hameed is not a physician as defined under the Act.[18] It is well established that the reports of a social worker do not constitute competent medical opinion evidence.[19] For this reason, these reports are of no probative value on the issue of appellant's accepted psychogenic pain disorder and are insufficient to overcome the weight accorded to Dr. Shah as a specialist in this field of medicine.

CONCLUSION

The Board finds that the Office met its burden of proof to terminate appellant's compensation as of June 25, 2009 for the accepted conditions of lumbar strains and psychogenic pain disorder.

[18] *See* 5 U.S.C. § 8101(2).

[19] *See Phillip L. Barnes*, 55 ECAB 426 (2004).

ORDER

IT IS HEREBY ORDERED THAT the February 24, 2010 decision of the Office of Workers' Compensation Programs be affirmed.

Issued: May 11, 2011
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