United States Department of Labor
Employees' Compensation Appeals Board

R.B., Appellant	)	
and	)	**Docket No. 11-1910**
	)	**Issued: March 27, 2012**
DEPARTMENT OF THE ARMY, SCHOFIELD BARRACKS POST OFFICE, Fort Shafter, HI, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On August 15, 2011 appellant filed a timely appeal from an April 26, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether OWCP properly terminated appellant's compensation benefits effective May 9, 2010 on the grounds that he had no residuals or disability causally related to his accepted employment-related injuries; and (2) whether appellant established that he had any continuing disability or residuals relating to his accepted back condition after May 9, 2010.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that on February 5, 2002 appellant, then a 52-year-old motor vehicle operator, sustained a lumbar strain as a result of lifting boxes at work. Appellant received medical treatment from Dr. Linda J. Rowan, Board-certified in physical medicine and rehabilitation. He was placed on the periodic rolls effective June 16, 2002 and has not returned to work.

In a January 9, 2009 report, Dr. David R. Dawson, a Board-certified orthopedic surgeon, examined appellant for a lower back work-related injury. He provided an accurate history of injury that on February 5, 2002 appellant experienced sharp back pain when he moved a large package. Dr. Dawson related that appellant underwent physical therapy and had taken Vicodin for pain management over the last seven years. His pain was located in the lower back radiating down the right leg to his foot and was aggravated by prolonged standing, sitting, walking and increased activity in the morning, which prevented him from working. Appellant also complained of significant depression. Upon examination, Dr. Dawson observed straight spine alignment with no tilt to the left or right, no kyphosis and no paraspinal spasms present. Range of motion of the knee in flexion and lateral bend to the left and to the right was restricted with pain. Straight leg raise testing was positive on the right with pain in the back at 70 degrees and normal on the left without pain in the back or thigh or leg. Dr. Dawson noted that a 2005 lumbar magnetic resonance imaging (MRI) scan revealed mild disc bulging at the L4-5 level and mild degenerative facet changes. He diagnosed lower back work-related injury, chronic lower back pain, probable right L4-5 radiculopathy, and history of depression related to injury. Dr. Dawson opined that appellant's findings may be related to neuroforaminal stenosis, aggravated by a bulging disc and referred him for a lumbar computerized tomography (CT) scan.

In a January 12, 2009 report, Dr. Dawson noted that he examined appellant following a CT scan of the lumbar spine and observed no change in symptoms. His examination findings were similar to the January 9, 2009 examination findings. Dr. Dawson reviewed the lumbar spine CT scan and observed multilevel disc bulging most notable at the L3-4 and L4-5 and facet degenerative changes at L3-4, L4-5 and L5-S1 that impact the neuroforaminal at the L3-4 level on the right. He diagnosed lower back work-related injury, chronic lower back pain, probable right L4 radiculopathy and a history of depression related to the injury. Dr. Dawson stated that appellant had made no significant progress towards returning to work over the past six years and would require chronic pain management if he was to return to a more functional level. He requested authorization for three lumbar epidural steroid injections and chronic pain management.

Appellant underwent epidural steroid injections in March. In a May 8, 2009 clinical note, Dr. Dawson stated that appellant underwent a series of three epidural steroid injections and did not want to pursue further treatment. He referred appellant to a chronic pain management group.

In a July 24, 2009 report, Dr. Hui Wang, Board-certified in physical medicine and rehabilitation, examined appellant for chronic lower back pain secondary to a work injury with right lower extremity involvement. He provided an accurate history of injury regarding the February 5, 2002 work injury. Dr. Wang observed that a January 2009 MRI scan showed facet degeneration most predominantly at L4-5 and L3-S1. Upon examination, he observed lumbar

range of motion forward flexion to about 40 degrees and extension to about 5 degrees. The pain was mainly in the lower lumbar to the right sacroiliac (SI) joint and the distal area. Motor strength was 5/5 while sitting and hip flexion, knee extension, abduction and adduction, were 5/5. Dr. Wang stated that appellant could sit daily but only stand for one hour. He diagnosed chronic lower back pain from work injury, lumbar disc disease with right radiculopathy, lumbosacral muscular strain and history of depression.

In an August 19, 2009 consultation report, Dr. Frederick W. Silver, a Board-certified surgeon, reviewed Dr. Dawson's January 12, 2009 report and noted diagnoses of lower back work-related injury, chronic lower back pain, probable right L4 radiculopathy, and history of depression related to the injury. A lumbar spine CT scan revealed multilevel disc bulging, particularly at L3-4 and L4-5, as well as facet degenerative changes in the lumbar spine that impacted on the neural foramina at L3-4 on the right. Dr. Silver reviewed appellant's history and conducted an examination. He opined that appellant had developed a chronic pain syndrome characterized by a strong disability belief system, a pain and somatic focus, and a reliance on medication for pain management. Dr. Silver stated that there appeared to be mild depression, which may be associated with perceived loss of function. He concluded that appellant had pain disorder with psychological factors and a general medical condition and probable depression, not otherwise specified, likely related at some level to his industrial injury and loss of functioning.

On January 29, 2010 OWCP referred appellant, together with a statement of accepted facts, to Dr. George Harper, a Board-certified orthopedic surgeon, for a second opinion medical examination. In a March 12, 2010 report, Dr. Harper provided an accurate history of injury that on February 5, 2002 appellant developed low back pain when he lifted some boxes at work. He reviewed appellant's history and medical records. Upon examination, Dr. Harper observed range of motion forward flexion to about 20 degrees and extension to 10 degrees. On palpation of the lumbar spine, he did not notice any real tenderness in the lumbar paravertebral muscles, tightness or guarding and no spasm. Dr. Harper noted that appellant was a little tender in the midline lumbosacral area and L4-5 and exquisitely tender around the superior aspect of his right sacroiliac joint. Seated straight leg raise test was negative on the left and positive for pain at 90 degrees on the right. Dr. Harper diagnosed resolved lumbar strain with coexisting mild lumbar degenerative disc disease L4-5 and L5-S1 and subjective radiculitis without objective evidence of nerve root injury. He opined that the conditions related to the injury of lumbar sprain had long since resolved on a more probable than not basis. Dr. Harper explained that any sprain would have resolved itself within six months of the time of injury. He noted that appellant's MRI scan over several years showed mild progress which would be a natural progression of the aging process. Dr. Harper concluded that there was no objective clinical evidence to support appellant's subjective complaint of low back pain and that he was able to return to work as a motor vehicle operator with restrictions related to his degenerative disc disease, not his work-related lumbar sprain. He stated that, although appellant had no evidence on physical examination to support his subjective complaints of low back pain, appellant's radiographic findings supported his subjective complaints for the nonaccepted condition of degenerative disc disease.

On April 8, 2010 OWCP issued a notice of proposed termination of appellant's disability compensation and medical benefits based on Dr. Harper's March 12, 2010 medical report. It found that Dr. Harper's report established that appellant's back condition had resolved and that

he no longer had any disability or residuals of his accepted back injury. Appellant was advised that he had 30 days to submit additional evidence in response to the proposed termination. No additional evidence was received.

In a decision dated May 7, 2010, OWCP finalized appellant's termination for medical and wage-loss compensation benefits effective May 9, 2010 based on the report of Dr. Harper.

On May 7, 2010 appellant requested an oral hearing. He stated that he sought legal assistance and was advised to be examined by Dr. Linda Rowan who rated appellant as reaching maximum medical rehabilitation.

In a January 24, 2011 letter, Howard L. Graham, appellant's counsel, contended that the September 12, 2002 statement of accepted facts (SOAF) was deficient because there was insufficient description of the mechanism of injury for the second opinion examiner to visualize the February 5, 2002 injury event in violation of FECA's Procedure Manual 2.809.5(f). He further alleged that Dr. Harper's March 12, 2010 medical report failed to explain how appellant's present back condition was not related to appellant's accepted injury when the 2009 CT scan supported that appellant continued to suffer from a back condition. Mr. Graham stated that Dr. Harper failed to explain why the accepted condition, which still existed, was no longer a residual of the accepted injury. He also contended that OWCP asked leading questions of Dr. Harper.

On January 28, 2011 a telephone hearing was held and appellant's counsel was present. Appellant related that he worked as a motor vehicle operator for the employing establishment and his job duties included loading and unloading vehicles and lifting heavy boxes. He stated that he could not do those tasks today because it required lifting, walking up and down stairs, and driving, which caused him back pain. Appellant reviewed the various physicians that he received medical treatment from. His counsel alleged that Dr. Harper failed to provide medical rationale explaining why appellant's current back condition was related to aging and not his accepted back injury. Counsel contended that OWCP also ignored Dr. Silva's report that appellant suffered from chronic pain syndrome and should have referred appellant to a referee physician.

In a November 15, 2010 clinical note, Dr. John M. Blair, a Board-certified orthopedic surgeon, noted that he examined appellant for longstanding back and right leg pain. He related that back pain was at 80 percent and leg pain at 20 percent with associated numbness, pins and needles. Examination of appellant's back revealed full range of motion with aggravation of pain and excellent strength throughout the lower extremities. Straight leg raise testing was provocative of radicular leg pain on the right side. No deformity or evidence of instability was noted. Dr. Blair diagnosed lumbar stenosis, lumbar radiculopathy and lumbar spine degenerative disc disease. He recommended appellant undergo another MRI scan as the previous MRI scan was over five years old.

In a November 27, 2010 lumbar MRI scan, Dr. Barbara A. Blankenship, a Board-certified diagnostic radiologist, noted a history of back pain with right-sided radiculopathy. She observed a diffuse posterior disc bulge with disc material extending into the inferior aspects of both neural foramen, left greater than right and moderate bilateral facet hypertrophy. Dr. Blankenship stated

that the bone marrow signal was within normal limits and noted mild dehydration of disc spaces at L2-S1. She diagnosed mild degenerative disc disease with most marked findings at L4-5.

In a December 8, 2010 clinical note, Dr. Blair noted appellant's complaints of ongoing back and leg pain radiating down to the foot and ankle. He related that the pain was aggravated with bending, lifting, sitting or standing. Dr. Blair reviewed a November 23, 2010 MRI scan which revealed moderate central canal narrowing at the L4-5 level related to facet arthropathy and degenerative changes at L5-S1. He diagnosed lumbar stenosis, lumbar radiculopathy and lumbar spine degenerative disc disease. Dr. Blair stated that appellant functioned relatively well as long as he used up to three tablets of Vicodin per day and explained that this was not an unreasonable quantity for chronic pain management.

By decision dated April 26, 2011, an OWCP hearing representative affirmed the May 7, 2010 decision terminating appellant's compensation based on Dr. Harper's March 12, 2010 medical report. It found that Dr. Harper's report represented the weight of medical evidence of the record to establish that appellant no longer had any disability or residuals causally related to his accepted back injury. The hearing representative pointed out that Dr. Harper provided an accurate history of injury and found that the questions were not sufficiently leading to invalidate the second opinion report.

LEGAL PRECEDENT -- ISSUE 1

According to FECA, once OWCP accepts a claim and pays compensation, it has the burden of justifying termination or modification of an employee's benefits.[2] OWCP may not terminate compensation without establishing that the disability had ceased or that it was no longer related to the employment.[3] OWCP's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[4] The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability compensation.[5] To terminate authorization for medical treatment, OWCP must establish that appellant no longer has residuals of an employment-related condition, which require further medical treatment.[6]

ANALYSIS -- ISSUE 1

OWCP accepted that on February 5, 2002 appellant sustained a lumbar strain as a result of lifting boxes at work. Appellant received disability compensation and has not returned to work. In a decision dated May 7, 2010, OWCP finalized its April 8, 2010 preliminary decision

[2] *S.F.*, 59 ECAB 642 (2008); *Kelly Y. Simpson*, 57 ECAB 197 (2005); *Paul L. Stewart*, 54 ECAB 824 (2003).

[3] *Jason C. Armstrong*, 40 ECAB 907 (1989); *Charles E. Minnis*, 40 ECAB 708 (1989); *Vivien L. Minor*, 37 ECAB 541 (1986).

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

[5] *T.P.*, 58 ECAB 524 (2007); *Kathryn E. Demarsh*, 56 ECAB 677 (2005); *A.P.*, Docket No. 08-1822 (issued August 5, 2009).

[6] *James F. Weikel*, 54 ECAB 660 (2003); *Pamela K. Guesford*, 53 ECAB 727 (2002); *A.P.*, *supra* note 5.

to terminate appellant's benefits finding that the medical evidence demonstrated that he no longer had any residuals or disability causally related to his accepted injury. By decision dated April 26, 2011, OWCP's hearing representative affirmed the May 7, 2010 termination decision based on the March 12, 2010 report of Dr. Harper who found that appellant no longer had residuals or disability related to his accepted back condition. The Board finds that OWCP met its burden of proof to terminate appellant's medical benefits for his accepted back injury as the medical evidence of record failed to establish that appellant had any continuing disability or residuals relating to his accepted back condition.

OWCP terminated appellant's compensation benefits based on the March 12, 2010 second opinion report of Dr. Harper who provided an accurate history of injury and reviewed appellant's medical records. Dr. Harper conducted an examination and diagnosed resolved lumbar strain with coexisting mild lumbar degenerative disc disease and subjective radiculitis without objective evidence of nerve root injury. He found no objective clinical evidence to support appellant's subjective complaint of low back pain and authorized appellant to return to work as a motor vehicle operator with restrictions related to his degenerative disc disease. Dr. Harper concluded that the conditions related to appellant's lumbar sprain injury had long since resolved and explained that any sprain would have resolved within six months time of the injury. He opined that appellant's worsening back condition was the natural progression of the aging process and not related to his accepted lumbar sprain condition.

The Board finds that this report is sufficiently detailed and well reasoned to constitute the weight of the medical opinion evidence.[7] Dr. Harper reviewed appellant's factual and medical history and provided findings on physical examination. While he explained that appellant's physical examination did not support his subjective complaints, he did find that the radiologic findings relative to appellant's nonaccepted degenerative aging process supported appellant's subjective complaints of pain. Dr. Harper responded to specific questions from OWCP and opined that appellant's employment-related conditions had resolved with no residuals or disability causally related to the accepted back injury.

Appellant submitted various reports from treating physicians to support his claim. While these physicians noted various diagnoses of degenerative lumbar conditions, depression and chronic pain syndrome, none of appellant's treating physicians provided any medical rationale to relate these conditions to appellant's accepted injury.

Dr. Dawson provided an accurate history of injury, reviewed appellant's medical records, and provided findings on examination. He diagnosed lower back work-related injury, chronic lower back pain, probative right L4-5 radiculopathy and history of depression related to injury. Although Dr. Dawson refers to a lower back work-related injury, he does not offer any rationalized medical explanation regarding how appellant's current back symptoms were causally related to his accepted work-related injury. He did not relate a medical history, or radiologic findings to support a conclusion that any of his current diagnoses were caused by the

[7] *See S.P.*, Docket No. 11-1323 (issued January 24, 2012).

accepted injury. Medical evidence that states a conclusion but does not offer any rationalized medical explanation regarding causal relationship is of limited probative value.[8]

Similarly, Dr. Wang also diagnosed chronic lower back pain from work injury but did not provide any medical rationale to support this conclusion. Accordingly, the Board finds that his report is also insufficient to establish appellant's claim.

Appellant also submitted a report by Dr. Silver who reviewed Dr. Dawson's reports and diagnosed lower back work-related injury, chronic lower back pain, probable right L4 radiculopathy and history of depression related to the injury. He stated that appellant had a pain disorder with psychological factors and a general medical condition likely related at some level to his industrial injury and loss of functioning. Dr. Silver's opinion that appellant's condition was "likely related" to his work injury is speculative in nature. Because medical opinions that are speculative or equivocal in character are of diminished probative value, his report also fails to support appellant's continuing employment-related disability.[9]

On appeal, appellant alleges that OWCP failed to consider the reports of Dr. Linda J. Rowan who treated him for his original injury in 2002 and opined that appellant had reached maximum rehabilitation. He stated that Dr. Harper only examined him for 15 minutes whereas Dr. Rowan performed the most testing and research of all his physicians. The Board notes, however, that Dr. Rowan last examined appellant in 2008. There is no other medical evidence contemporaneous with the termination of appellant's benefits which supports that he has any continuing residuals or disability related to his accepted work injury.

The Board finds that the weight of the medical evidence is represented by Dr. Harper's March 12, 2010 report and that OWCP met its burden of proof to terminate appellant's compensation and medical benefits as the evidence establishes no continuing employment-related disability or medical residuals. Because Drs. Dawson, Wang and Silver did not offer any medical reasoning explaining how appellant's current back symptoms were related to his employment injury, their reports are not sufficient to create a conflict with Dr. Harper's well-reasoned report.[10]

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

LEGAL PRECEDENT -- ISSUE 2

As OWCP met its burden of proof to terminate appellant's compensation benefits, the burden shifted to him to establish that he had disability causally related to his accepted

[8] *J.F.*, Docket No. 09-1061 (issued November 17, 2009); *A.D.*, 58 ECAB 149 (2006).

[9] *D.D.*, 57 ECAB 734, 738 (2006); *Kathy A. Kelley*, 55 ECAB 206 (2004).

[10] *J.C.*, Docket No. 11-1189 (issued January 19, 2012).

employment injury.[11] To establish a causal relationship between the condition, as well as any disability claimed and the employment injury, appellant must establish by the weight of the reliable, probative and substantial evidence that he had an employment-related disability, which continued after termination of compensation benefits.[12]

ANALYSIS -- ISSUE 2

The Board finds that appellant has not established that he has any continuing residuals of his work-related lumbar strain on or after May 9, 2010.

Following OWCP's termination of his compensation and medical benefits, appellant submitted reports from Dr. Blair dated November 15 and December 8, 2010. Dr. Blair noted appellant's complaints of back and right leg pain and provided findings on examination. He diagnosed lumbar stenosis, lumbar radiculopathy and lumbar spine degenerative disc disease. Dr. Blair did not, however, offer any opinion regarding the cause of appellant's back condition or explanation regarding whether appellant's back symptoms were causally related to his accepted February 5, 2002 work injury. Thus, his reports are of limited probative value on the issue of causal relationship.[13] Likewise, Dr. Blankenship's November 27, 2010 MRI scan report also failed to provide any opinion on whether appellant's back symptoms were related to his work-related injury.

None of the reports submitted by appellant after the termination of benefits included a rationalized opinion regarding the causal relationship between his current back symptoms and his accepted work-related conditions. Thus, the Board finds that appellant did not establish that he had any employment-related residuals or disability after May 9, 2010.

CONCLUSION

The Board finds that OWCP met its burden of proof to terminate appellant's disability compensation and medical benefits effective May 9, 2010 and that appellant failed to establish that he had any continuing disability related to his accepted back condition after May 9, 2010.

[11] *Joseph A. Brown, Jr.*, 55 ECAB 542 (2004); *Manuel Gill*, 52 ECAB 282 (2001); *George Servetas*, 43 ECAB 424, 430 (1992).

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

[13] *R.E.*, Docket No. 10-679 (issued November 16, 2010); *K.W.*, 59 ECAB 271 (2007).

ORDER

IT IS HEREBY ORDERED THAT the April 26, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 27, 2012
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board