United States Department of Labor
Employees' Compensation Appeals Board

H.B., Appellant	)	
and	)	**Docket No. 15-262**
	)	**Issued: May 19, 2015**
DEPARTMENT OF HEALTH & HUMAN SERVICES, PHOENIX AREA INDIAN HEALTH SERVICE, Phoenix, AZ, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On November 17, 2014 appellant filed a timely appeal from a November 5, 2014 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.

ISSUE

The issue is whether OWCP met its burden of proof to justify termination of appellant's medical and wage-loss compensation benefits for his accepted injury effective November 5, 2014.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On November 26, 2012 appellant, then a 55-year-old maintenance mechanic, filed a traumatic injury claim (Form CA-1) alleging that, on November 19, 2012, he was cleaning grass from cracks in a ramp area when he fell forward and struck the top of his head on a pole. He stated that, as a result of this event, he suffered head trauma and a concussion. OWCP accepted the claim for a concussion without loss of consciousness on December 4, 2012. On February 14, 2013 it accepted the additional condition of postconcussion syndrome.

In a medical record dated November 19, 2012, Dr. Roy Teramoto, Board-certified in pediatrics, stated that he was called to see appellant at 10:30 a.m. on the date of injury. Appellant was sitting in a chair, had his head down with his eyes closed, and had clear mucous dripping from his nose. He would respond to verbal questions but did not consistently provide a coherent response. Appellant did not reportedly lose consciousness, but complained of a headache and stumbling. Dr. Teramoto noted that appellant was a diabetic, on seizure medication, and had previous surgery for a brain tumor in 2010.

In a radiological report dated November 19, 2012, Dr. Barbara E. Carr, a Board-certified diagnostic radiologist, interpreted the results of a computerized tomography (CT) scan of appellant's brain. She stated an impression of postoperative changes with a craniotomy defect of the right parietal bone, with no acute intracranial findings, and minimal inflammatory changes of the paranasal sinuses.

On November 19, 2012 Dr. John B. Carson, Board-certified in emergency medicine, stated that appellant was bending over at work and struck his head on a pipe. He noted that appellant was not knocked out, but was stunned. Dr. Carson stated that appellant did not fall but was struck on the top of his head. Appellant complained of headache and photophobia. Dr. Carson noted, "[Appellant] was medicated for pain. Laboratory studies were checked. There was no contraindication at discharge. [His] CT scan was negative except for postoperative changes with a craniotomy defect. [Appellant] had a meningioma some years ago." He assessed appellant with a post-traumatic migraine.

In progress notes dated November 27, 2012, Dr. Antonio Rivera diagnosed appellant with a concussion with residual symptoms and recommended that he rest at home for the next eight days.[2] He noted that appellant had postconcussion symptoms with no apparent neurological deficit, but that he was still dizzy and had intense left shoulder pain. On December 5, 2012 Dr. Rivera stated that appellant should not work until December 10, 2012 unless cleared by a neurologist.

By letter dated December 6, 2012, OWCP stated:

> "The available medical records show that [appellant] currently takes nine prescription medications for conditions including epilepsy, hypertension, type II diabetes, hyperlipidemia, and depression. Because you hit an intervening object

[2] Dr. Rivera's certification in a medical specialty could not be confirmed with the American Board of Medical Specialties or the American Osteopathic Association.

> when you fell, we will not be required to determine the cause of the fall. However, the claim is accepted only for a concussion without loss of consciousness and not any of his preexisting conditions."

On December 10, 2012 Dr. Rawinson D. Fernando, Board-certified in psychiatry and neurology, stated:

> "This is a 55-year-old male with multiple problems who has had meningioma removed from the right parietal head region and has had seizures during this time and it is unsure whether the seizure disorder is proceeding or after the surgical evacuation [of] the meningioma.
>
> "[Appellant] is on Keppra for the seizure disorder. On November 19, 2012 he apparently had an accidental fall and hit his head on a pipe but no loss of consciousness per [emergency room] notes.... [Appellant] apparently did not have a seizure during this episode."

He diagnosed appellant with a seizure disorder. Dr. Fernando noted:

> "[Appellant] is having chronic headaches, dizziness, and other multiple complaints which are not new to him. [He] should not be working on heights on view of the history of seizure disorder. Seizure precautions need to be taken, working with heavy machinery as he has a history of seizure disorder.
>
> "Regarding [appellant's] present injury, which made him go to the emergency room, he has had no residual effect on him."

In a note dated December 11, 2012, Dr. Rivera recommended that appellant return to work the next day, with restrictions of working at ground level and no operation of machinery. Additionally, he noted that, due to appellant's left shoulder disability, he should do only clerical or supervisory work, with no physical work as before.

Appellant was not working as of December 14, 2012 because the employing establishment did not have work available within his restrictions.

By letter dated December 20, 2012, OWCP noted that claim number xxxxxx094 was accepted for an August 2010 left shoulder rotator cuff sprain and arthropathy. On December 13, 2012 it denied a claim for recurrence under claim number xxxxxx094. Claim number xxxxxx185 was accepted for a collapse due to heat exhaustion on September 17, 2012. OWCP stated, "Please note that the claim is not accepted for any left shoulder condition as the medical evidence in claims xxxxxx185 and xxxxxx094 do not demonstrate that a new condition or material change of the left shoulder occurred when [appellant] collapsed due to heat exhaustion on September 17, 2012."

On December 28, 2012 OWCP referred appellant for a second opinion examination with Dr. Thomas A. Schweller, Board-certified in psychiatry and neurology.

In a duty status report dated January 3, 2013, Dr. Rivera recommended that appellant return to work with permanent restrictions of no more than 6 hours of continuous pulling/pushing per day, 4 hours of continuous walking per day, 15 minutes of intermittent kneeling or twisting, and no climbing, bending, stooping, or operating machinery. He also noted that appellant should not continuously lift or carry more than 15 pounds or intermittently lift or carry 30 pounds.

On January 17, 2013 Dr. Schweller examined appellant and diagnosed him with a closed head injury with concussion; postconcussion syndrome with balance impairment, cognitive impairment, and headaches; cervical strain; and left shoulder strain with partial ankyloses. He noted, "This gentleman has clear residual injuries from his work accident.... There continues to be post[-]traumatic head syndrome associated with cognitive impairment, mood impairment, dizziness, and headaches.... The findings are due to concussion."

By letter dated February 15, 2013, OWCP informed appellant that he was to be placed on the periodic rolls for compensation, effective January 4, 2013.

In a work capacity evaluation dated March 23, 2013, Dr. Rivera stated that appellant was unable to work due to his postconcussion syndrome.

On July 26, 2013 appellant was seen by Drs. Paul E. Bendheim and Joshua A. Tobin, Board-certified neurologists. They diagnosed appellant with postconcussive syndrome with severe headaches and memory impairment; migraine headaches without aura; obstructive sleep apnea treated with continuous positive airway pressure; status post meningioma; a single seizure postsurgery in 2010; and diabetic distal sensory neuropathy. Drs. Bendheim and Tobin noted that it was conceivable that a seizure could have been responsible for his fall in November 2012. They recommended a magnetic resonance imaging (MRI) scan, an electroencephalogram (EEG), laboratory evaluation, and a neuropsychological evaluation.

In a diagnostic report dated August 12, 2013, Dr. Tadesse Eshetu, a Board-certified radiologist, interpreted the results of an MRI scan of appellant's brain. He found no acute intracranial process and no evidence of a traumatic brain injury or acute blood; mild sequale of migrainous angiopathy versus chronic microangiopathic changes; minimal paranasal sinus mucosal inflammation without evidence of acute sinusitis; and a status post right frontolateral craniotomy with no residual mass identified.

In a report dated October 1, 2013, Dr. Tobin reiterated that appellant was off work status. He noted that appellant was having trouble sleeping and depression. On December 4, 2013 Dr. Tobin reported that appellant had a sensation of déjà vu while driving, when he pulled over to the side of the road and passed out. Appellant also had high levels of emotional distress. On January 27, 2014 Dr. Tobin noted that appellant told him that he had no headaches prior to being hit on the back of the head in August 2012. He further noted that when an opiate such as hydrocodone is used, taking pain medications more than eight days per month tends to cause headaches, and that this could be part of appellant's problem as he was taking pain medication daily. In a report dated February 17, 2014, Dr. Tobin stated that it was reasonable to attribute appellant's headaches to his injury and that it was not an aggravation of a preexisting condition. Appellant remained disabled from work.

On June 19, 2014 OWCP referred appellant to Dr. Kenneth Stover, a neurosurgeon, for a second opinion evaluation as to whether appellant was capable of some type of work or whether he was at maximum medical improvement.[3] Dr. Stover examined appellant on July 17, 2014. He diagnosed appellant with postconcussion syndrome by history; cognitive and emotional findings by history; and a status post right frontal convexity meningioma by history. Dr. Stover stated, "At the present time, after review of [appellant's] medical records and taking of his history and performing neurologic exam[ination] it is difficult for me to arrive at the diagnosis of postconcussive syndrome clearly. [His] headaches are not continuous which is not consistent with the postconcussion syndrome, but are usually other cognitive and emotional changes are associated. I am also not in favor of pseudotumor cerebri and not clear as to removal of spinal fluid would produce much of an effect. I have no objective findings in [appellant] at the present time." He stated that appellant's headaches were of unknown origin and therefore appellant was not at maximum medical improvement because it was not known how they could be properly managed.

On May 20, 2014 appellant underwent a successful lumbar puncture. There were no complications.

On September 4, 2014 OWCP proposed to terminate appellant's compensation for medical benefits and wage loss, finding that the weight of the medical evidence established no continuing residuals from postconcussion syndrome.

In a report dated September 29, 2014, Dr. Tobin responded to Dr. Stover's second opinion evaluation. He summarized his previous reports and examinations of appellant and diagnosed him with pseudotumor cerebri and postconcussive syndrome. Dr. Tobin stated:

> "I respectfully disagree with the conclusions that [appellant's] headaches are unrelated to is ICA injury and that he has no objective evidence of any disabling condition in the report dated September 4, 2014. First, Dr. Stover argues that, since his head pain is continuous, his head pain cannot be from postconcussive syndrome. While postconcussive headaches can be intermittent, they can also be continuous, as nowhere in the International Headache Society's International Classification of Headache Disorders ... is post-traumatic headache required to be intermittent.... Dr. Stover also notes ... that the reason for his headaches has not been established. In reality, it has ... the report never mentions any of my own office notes ... in which [appellant] consistently reports disabling head pain. Two different neurologists, myself and Dr. Bendheim, have opined that he has post-traumatic headaches. Finally, it is entirely reasonable that [appellant's] headaches are a direct result of his injury. First, he meets the IHS criteria for post[-]traumatic headaches. Second, [appellant's] head injury could have specifically caused his pseudotumor pathology by way of causing increased protein deposition on the arachnoid villi which reabsorb CSF fluid. Since the villi would therefore be less efficient at absorbing CSF fluid, [stated] fluid would tend to build up, increasing the pressure in his head. Also, because being overweight

[3] Dr. Stover's certification in a medical specialty could not be confirmed with the American Board of Medical Specialties or the American Osteopathic Association.

is a significant risk factor for pseudotumor cerebri, it is possible that [appellant's] head injury led to depressed physical activity, that in turn led to weight gain."

By letter dated October 8, 2014, OWCP informed appellant that it had determined a conflict in the medical evidence existed between Drs. Tobin and Stover, and scheduled a referee examination with a neurologist. The proposed termination would be reviewed once the referee report had been received. The case record reveals that OWCP began the process of scheduling a referee examination but did not receive a report from a referee examiner before terminating appellant's benefits.

OWCP finalized its termination of appellant's medical benefits and wage-loss compensation on November 5, 2014 without reference to a referee report. Instead, it based its finalization of termination on Dr. Stover's July 17, 2014 report, finding that the weight of medical evidence rested with him.

LEGAL PRECEDENT

Once OWCP accepts a claim, it has the burden of justifying termination or modification of compensation benefits.[4] After it has determined that an employee has disability causally related to his or her federal employment, OWCP may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment.[5] 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, OWCP must establish that a claimant no longer has residuals of an employment-related condition, which requires further medical treatment.[6]

FECA provides that, if there is a 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 the examination.[7] The implementing regulations state that if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee or impartial examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[8]

[4] *Gewin C. Hawkins*, 52 ECAB 242, 243 (2001); *Alice J. Tysinger*, 51 ECAB 638, 645 (2000).

[5] *Mary A. Lowe*, 52 ECAB 223, 224 (2001).

[6] *Id.; Leonard M. Burger*, 51 ECAB 369, 369 (2000).

[7] 5 U.S.C. § 8123(a).

[8] 20 C.F.R. § 10.321.

To be of probative value, a medical opinion must be based on a complete factual and medical background, must be of reasonable medical certainty, and be supported by medical rationale.[9] Medical rationale is a medically sound explanation for the opinion offered.[10]

It is well established that, when a case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background, must be given special weight.[11]

ANALYSIS

The Board finds that OWCP did not meet its burden to justify termination of benefits, as there is an unresolved conflict in medical opinion between Dr. Stover and Dr. Tobin.[12] For a conflict to arise, the opposing physicians' viewpoints must be virtually equal weight and rationale.[13] It is OWCP that bears the burden to justify modification or termination of benefits.[14]

OWCP based its decision to terminate appellant's benefits on a July 17, 2014 report by Dr. Stover, the second opinion physician, who conducted a physical examination and reviewed his medical history. Dr. Stover concluded that the origin of appellant's headaches were unknown but that they were not consistent with the accepted condition of postconcussion syndrome.

In a September 29, 2014 report, Dr. Tobin indicated that appellant's symptoms were in fact consistent with postconcussion syndrome and that Dr. Stover's July 17, 2014 report was flawed. He additionally diagnosed appellant with pseudotumor cerebri, noting that his head injury could have caused this pathology.

OWCP itself determined that a conflict in medical opinion existed between Drs. Stover and Tobin and advised appellant as such in a letter dated October 8, 2014. Drs. Stover and Tobin both reviewed appellant's medical history and conducted physical examinations. However, their findings are significantly divergent. Dr. Stover opines that appellant's postconcussive syndrome has resolved and is not currently the cause of his symptoms, whereas Dr. Tobin opines that postconcussive syndrome and pseudotumor cerebri, both caused by the November 19, 2012 work-related injury, continued to be present. Thus, the Board finds that OWCP did not meet its burden of proof to terminate appellant's compensation benefits effective November 5, 2014. As of that date a conflict in medical opinion existed between Dr. Stover and Dr. Tobin. Each

[9] *Jennifer Atkerson*, 55 ECAB 317, 319 (2004).

[10] *See Ronald D. James, Sr.*, Docket No. 03-1700 (issued August 27, 2003); *Kenneth J. Deerman*, 34 ECAB 641 (1983) (the evidence must convince the adjudicator that the conclusion drawn is rational, sound, and logical).

[11] *Gloria J. Godfrey*, 52 ECAB 486, 489 (2001).

[12] FECA provides that, if there is disagreement between the physician making the examination for OWCP and the employee's physician, OWCP shall appoint a third physician who shall make an examination. *See* 5 U.S.C. § 8123(a); *Shirley L. Steib*, 46 ECAB 309, 317 (1994).

[13] *Darlene R. Kennedy*, 57 ECAB 414 (2006).

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

physician had the opportunity to examine appellant and review the diagnostic studies of record. With respect to the existence and extent of any ongoing employment-related residuals, the Board finds that the relevant and probative medical evidence is in equipoise.

As OWCP failed to base its decision on resolution of the opinion evidence, the Board finds that it did not meet its burden of proof to terminate appellant's benefits. Referral to an impartial medical specialist is warranted. Accordingly, OWCP's decision to terminate appellant's compensation and medical benefits is reversed.

CONCLUSION

The Board finds that OWCP did not meet its burden of proof to terminate appellant's compensation benefits effective November 5, 2014.

ORDER

IT IS HEREBY ORDERED THAT the November 5, 2014 decision of the Office of Workers' Compensation Programs is reversed.

Issued: May 19, 2015
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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