United States Department of Labor
Employees' Compensation Appeals Board

H.A., Appellant	)	
and	)	**Docket No. 15-1351**
	)	**Issued: July 1, 2016**
DEPARTMENT OF VERTERANS AFFAIRS, PALO ALTO HEALTH CARE SYSTEM, Menlo Park, CA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On June 1, 2015 appellant filed a timely appeal from a March 9, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] Pursuant to the Federal Employees' Compensation Act[2] (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 terminate appellant's wage-loss compensation and medical benefits effective March 1, 2015.

[1] Appellant timely requested oral argument before the Board. By order dated February 25, 2015, the Board exercised its discretion and denied the request as the issue on appeal could be adequately addressed based on a review of the case record. *See Order Denying Request for Oral Argument*, Docket No. 15-1351 (issued February 25, 2015).

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On February 9, 2012 appellant, then a 56-year-old nursing assistant, sustained a low back injury in the performance of duty after lifting a patient from the ground into a bed. He stopped work on February 13, 2012 and returned to work on February 20, 2012. Appellant worked intermittently on modified duty thereafter. OWCP accepted the claim for lumbar sprain/strain and radiculitis.[3]

Initial medical reports diagnosed sprain or strain of the lumbar region and lumbar radiculopathy. In a July 3, 2012 report, Dr. John Kaufman, Board-certified in diagnostic radiology and neuroradiology, advised that a magnetic resonance imaging (MRI) scan of the lumbar spine revealed mild degenerative changes in the lumbar spine as compared to a previous May 15, 2006 MRI scan. In particular he noted a broad-based disc bulge with mild canal narrowing not significantly changed at L1-2, mild disc bulge without canal or foraminal narrowing at L2-3, unchanged mild broad-based disc bulge with bilateral foraminal narrowing at L3-4, a new tiny right paracentral disc protrusion with mild narrowing at the right lateral recess and unchanged mild bilateral foraminal narrowing at L4-5, and unchanged mild bilateral foraminal narrowing at L5-S1. In a November 8, 2012 report, Dr. Mark Sontag, a Board-certified physiatrist, advised that appellant complained of back pain, radiating bilateral leg pain, numbness, and tingling. He noted that on February 9, 2012 appellant was lifting a 320-pound patient into bed when he noted increased back, neck, arm, and leg pain. On examination Dr. Sontag noted lumbar flexion extension at 30 degrees, tenderness at the L5-S1 interspace, 4/5 weakness in the left iliopsoas and quadriceps, and straight leg raising at 40 degrees. He advised that appellant had multilevel disc disease with some stenosis and recommended a functional restoration pain management program. Dr. Sontag continued submitting reports indicating that appellant remained symptomatic

On April 4, 2013 OWCP referred appellant, together with the medical record and a statement of accepted facts to Dr. Aubrey Swartz, a Board-certified orthopedic surgeon, for a second opinion regarding appellant's status and whether he had any residuals of his accepted conditions. In an April 30, 2013 report, Dr. Swartz noted the history of appellant's injury and treatment. On examination he noted lumbar ranges of motion and advised that there was tenderness to lighter touch in the sciatic notches, and increased pain with knees partially flexed when face down in the prone position with internal and external rotation of both feet and ankles. Dr. Swartz opined that the diagnosis of L4-5 disc protrusion with mild narrowing at the right lateral recess with bilateral L4 radiculopathy was inconsistent with the July 3, 2012 MRI scan. He noted that the MRI scan only revealed a "tiny" protrusion at L4-5, no evidence of radiculopathy, mild degenerative changes, no disc herniation, no evidence of any nerve root compression, and no evidence of spinal cord compression. Dr. Swartz highlighted that appellant's pain drawing from Dr. Sontag's office contained symmetrical and neat markings in an orderly fashion which was characteristic of nonorganic pain. He also noted finding many inconsistencies in his examination that were not medically valid. Dr. Swartz advised that appellant essentially had a normal examination with no neurologic findings and opined that

[3] OWCP had previously accepted low back strain after appellant slipped on coffee at work on May 5, 2003. Appellant was released to full-duty work on May 16, 2003. This prior claim is not presently before the Board.

appellant's low back complaints had no relation to the February 9, 2012 work incident. He described the injury as questionable with a possible soft tissue strain that likely subsided within the first two to three months of the claim or at least by May 9, 2012. Dr. Swartz noted that there was no further treatment needed and that appellant was overmedicated. He opined that appellant had no restrictions and was capable of returning to his usual job as a nursing assistant.

By letter dated June 11, 2013, OWCP advised appellant that it proposed a termination of wage-loss and medical compensation benefits based on the opinion of Dr. Swartz.

Appellant provided a June 10, 2013 report from Dr. Sontag who advised that he had reviewed Dr. Swartz' April 3, 2013 report and disagreed with his findings. In response to the assertion that appellant's pain drawing had symmetrical marking characteristic of nonorganic pain, he argued that the pain diagram was consistent with the L4-5 degenerative disc bulge and foraminal narrowing causing bilateral L4 and L5 pain. Dr. Sontag also disagreed with Dr. Swartz' assertion that there was no MRI scan evidence of radiculopathy. He argued that lumbar radiculopathy is a clinical diagnosis that is arrived at by taking an accurate history followed by a clinical examination, not based on MRI scan. Dr. Sontag disputed Dr. Swartz' assessment that appellant was overmedicated with no need for further treatment. He advised that appellant sustained a significant low back injury that resulted in persistent pain and disability, which required further treatment, including L4 transformational epidural injections and a functional restoration pain management program.

In a November 7, 2013 report, Dr. Sontag referred appellant for cognitive behavioral therapy to treat chronic pain and reactive depression.

In a September 3, 2013 report, Dr. Kimeron Hardin, a psychologist, advised that appellant continued to work full time, which was painful and difficult. She diagnosed severe depression and moderate anxiety. Dr. Hardin opined that continuing to work with pain was exhausting for appellant and that he became depressed in response to working under those conditions. She also noted that he was on quite a bit of medication which helped him to function minimally, but the side effects were potentially contributing to his worsening mood and fatigue. Dr. Hardin continued to submit reports noting appellant's status.

By letter dated July 9, 2014, OWCP informed appellant that it had found a conflict in the medical evidence between Dr. Sontag and Dr. Swartz and scheduled a referee examination with Dr. Charles Sciaroni, a Board-certified orthopedic surgeon. The appointment was schedule for August 4, 2014. Appellant failed to report for his scheduled referee examination. On October 30, 2014 OWCP proposed to suspend his medical benefits and compensation for failure to report to the referee examination.

In a November 5, 2014 report, Dr. Sontag advised that appellant's condition remained unchanged and that he continued to experience severe depression and anxiety. He assessed L4-5 and L5-S1 disc bulges, chronic L5 and S1 radicular pain, and severe reactive depression. Dr. Sontag advised that on February 9, 2012 appellant sustained a severe back injury as a result of lifting a 300-pound patient. He noted that due to this severe back injury appellant developed

severe reactive depression. Dr. Sontag advised that appellant's disability started on September 27, 2014 and would extend through April 27, 2015.[4]

By decision dated November 13, 2014, OWCP finalized the proposed suspension. In a November 4, 2014 statement, appellant advised that he had moved to a new address and had not received any documents notifying him of a scheduled examination. His benefits were restored and, on November 21, 2014, the referee examination was rescheduled with Dr. Sciaroni on December 15, 2014.

In a December 16, 2014 report, Dr. Sciaroni noted the history of appellant's injury and treatment. On examination, findings included a guarded gait, active lumbar extension of 15 degrees, forward flex with fingertips to distal thighs with pain, and 80 degrees sitting straight leg raising bilaterally. Motor examination of the lower extremities was normal. Dr. Sciaroni opined that appellant sustained a lumbar sprain or strain on February 9, 2012 and agreed with Dr. Swartz that the injury healed within three months or by May 9, 2012 and that none of the treatment and evaluation since that time was reasonable or necessary. He further opined that appellant's July 3, 2012 lumbar MRI scan revealed age-appropriate findings and that it was medically probable that appellant's symptoms did not relate to the work-related incident. Dr. Sciaroni opined that the distribution of apparently diminished left trunk and left lower extremity light-touch sensation, and marked supine restriction of active knee flexion with complaints of low back pain radiating to the knees was inconsistent with organic disease or any physical degenerative or traumatic disease process. He also questioned appellant's credibility given the fact that he denied having prior back symptoms aside from an episode 25 years prior, yet the record reflected a lumbar steroid epidural injection in 2008 and a May 15, 2006 lumbar MRI scan. Dr. Sciaroni opined that Dr. Sontag was treating appellant's symptoms which were not explainable based on objective diagnostic testing. He further opined that there were no objective abnormalities on current musculoskeletal and neurologic examinations and that there was no impairment for appellant's regular job as a nursing assistant related to the February 9, 2012 injury.

In a January 14, 2015 report, Dr. Sontag advised that appellant was still experiencing back pain and posterior left leg pain to the heel. He noted that appellant was very frustrated and depressed regarding his pain. On examination Dr. Sontag noted lumbar flexion of 45 degrees, extension to 10 degrees, side bend to the right at 20 degrees, side bend to the left at 10 degrees, rotation with extension five degrees to the left, and 10 degrees to the right all eliciting pain. Examination also revealed tenderness to palpation over the midline from L4 to S1 and over the SI joint and seated straight leg raise test on the right to 80 degrees and 7 degrees of the left both eliciting pain. Dr. Sontag assessed L4-5 and L5-S1 disc bulges, chronic L5 and S1 radicular pain and severe reactive depression.

By letter dated January 29, 2015, OWCP proposed to terminate wage-loss and medical compensation benefits. It advised that the weight of the evidence was represented by Dr. Sciaroni's opinion.

[4] On October 28, 2014 appellant claimed wage-loss compensation beginning September 22, 2014. OWCP denied this claim on December 2, 2014.

In a February 6, 2015 statement, appellant advised that he wanted to speak to a judge because he believed that the Department of Labor had discriminated against him by denying his benefits and that the medical documentation was sufficient to explain his disability. He also resubmitted Dr. Sontag's November 5, 2014 report.

In a February 13, 2015 report, Dr. Dimitriy Kondrashov, a Board-certified orthopedic surgeon, advised that appellant was experiencing worsening back pain radiating into the left buttocks and leg, numbness in the left anterior thigh, and bilateral knee pain. He noted that appellant had been disabled from work since August 2014 due to worsening symptoms. Dr. Kondrashov noted appellant's treatment history and diagnostic imaging results. On examination he found that appellant had difficulty getting up from a seated position, moderate tenderness to palpation in the lumbosacral junction and over the left sacroiliac joint, restricted lumbar extension, forward flexion down to the knees, core deconditioning, ability to tandem walk, ability to walk on heels and toes, and weakness in the left-sided quadriceps. Dr. Kondrashov assessed worsening low back pain, left-sided radicular pain, quadriceps weakness, and anterior thigh numbness. He requested a lumbar spine MRI scan and radiographs to clarify neurocompressive pathology.

By decision dated March 9, 2015, OWCP terminated appellant's compensation benefits effective March 1, 2015. It found that the weight of medical opinion was represented by Dr. Sciaroni.

LEGAL PRECEDENT

Once OWCP accepts a claim and pays compensation, it has the burden of justifying modification or termination of an employee's benefits. After it has determined that an employee has disability causally related to his or her federal employment, it may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.[5] The right to medical benefits for an accepted condition is not limited to the period of entitlement to compensation for disability. 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]

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

[5] *Kenneth R. Burrow*, 55 ECAB 157 (2003).

[6] *Furman G. Peake*, 41 ECAB 361 (1990).

[7] 5 U.S.C. § 8123(a).

will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[8]

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.[9]

ANALYSIS

OWCP originally accepted appellant's claim for lumbar sprain/strain and radiculitis. Appellant received medical benefits based on the accepted conditions. OWCP referred appellant to Dr. Swartz for a second opinion regarding the status of his accepted conditions. Dr. Swartz advised that appellant essentially had a normal examination with no neurologic findings and opined that appellant's low back complaints had no relation to the February 9, 2012 work incident. He opined that appellant's soft tissue strain long subsided within the first two to three months or at least by May 9, 2012. Dr. Swartz noted that there was no further treatment needed and appellant was capable of returning to his usual job as a nursing assistant. However, appellant's treating physician, Dr. Sontag differed in that he advised that appellant sustained a significant low back injury at work that resulted in persistent pain and disability, which required further treatment. OWCP found that this created a conflict of medical opinion. Therefore, in accord with 5 U.S.C. § 8123(a), OWCP properly referred the case to Dr. Sciaroni for a referee examination and an opinion as to whether appellant continued to have employment-related residuals.

In his December 16, 2014 report, Dr. Sciaroni reviewed appellant's history, reviewed the medical evidence of record, and noted findings on examination. He opined that appellant sustained a lumbar sprain or strain on February 9, 2012 and indicated that the injury healed within three months or by May 9, 2012. Dr. Sciaroni noted that appellant's July 3, 2012 lumbar MRI scan revealed age-appropriate findings not productive of symptoms and that Dr. Sontag was treating appellant's symptoms, which were not explainable based on objective diagnostic testing. Dr. Sontag explained that the distribution of apparently diminished left trunk and left lower extremity light-touch sensation, as well as marked supine restriction of active knee flexion with complaints of low back pain radiating to the knees was inconsistent with organic disease or any physical degenerative or traumatic disease process. He opined that there were no objective abnormalities on current musculoskeletal and neurologic examinations and that appellant had no disability for his regular job related to the February 9, 2012 work injury.

The Board finds that the weight of the medical evidence rests with the well-rationalized report of Dr. Sciaroni. Dr. Sciaroni's opinion is based on a complete and accurate factual and medical history and is entitled to special weight as 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

[8] 20 C.F.R. § 10.321.

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

background, must be given special weight.[10] The Board finds that OWCP met its burden of proof to terminate wage-loss compensation effective March 1, 2015.

In his November 5, 2014 and January 14, 2015 reports, Dr. Sontag assessed L4-5 and L5-S1 disc bulges, chronic L5 and S1 radicular pain, and severe reactive depression. Furthermore, he failed to explain how the accepted lumbar strain and radiculitis caused or aggravated severe reactive depression. This is especially important where Dr. Sontag's diagnosed conditions were not accepted by OWCP as employment related.[11] 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.[12]

On February 13, 2015 Dr. Kondrashov assessed worsening low back pain, left-sided radicular pain, quadriceps weakness, and anterior thigh numbness. The Board finds that these reports are of diminished probative value and do not overcome the weight of Dr. Sciaroni's report or to create a new medical conflict as they fail to specifically address whether appellant's accepted conditions continued.[13]

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.

CONCLUSION

The Board finds that OWCP met its burden of proof to terminate appellant's wage-loss compensation and medical benefits.

[10] *Id*.

[11] *See Jaja K. Asaramo*, 55 ECAB 200 (2004) (where an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury).

[12] *I.J.*, 59 ECAB 408, 414 (2008).

[13] *Supra* note 11.

ORDER

IT IS HEREBY ORDERED THAT the March 9, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 1, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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