United States Department of Labor
Employees' Compensation Appeals Board

N.C., Appellant	)	
and	)	**Docket No. 15-1855**
	)	**Issued: June 3, 2016**
DEPARTMENT OF THE NAVY, MILITARY SEALIFT COMMAND, Norfolk, VA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 11, 2015 appellant, through counsel, filed a timely appeal from an August 19, 2015 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 met its burden of proof to terminate appellant's wage-loss compensation and medical benefits effective November 19, 2013; and (2) whether appellant has established continuing disability after November 19, 2013.

FACTUAL HISTORY

On February 6, 2010 appellant, then a 54-year-old able seaman, filed a traumatic injury claim (Form CA-1) alleging that on that day he sustained an injury when waves rocked the barge

[1] 5 U.S.C. § 8101 *et seq.*

he was on causing him to fall and hit his chest. He stopped work on February 9, 2010. The claim was accepted for chest contusion and lumbar strain under OWCP File No. xxxxxx672.

On March 1, 2010 appellant filed another traumatic injury claim alleging that on January 20, 2010 he sustained injury to the right shoulder and mid-lower back when a door slammed open, hit his right shoulder, and pushed his back into a solid pipe. By decision dated December 27, 2011, OWCP accepted his claim for lumbosacral radiculitis of the bilateral lower extremities, lumbar acquired spondylolisthesis, and L5 spondylosis under File No. xxxxxx619. Appellant filed a claim for compensation (Form CA-7) for the period April 1, 2010 through January 10, 2012.

On January 3, 2012 OWCP combined the current case under File No. xxxxxx672 with appellant's recently accepted claim, File No. xxxxxx619, which became the master file.

On January 31, 2012 OWCP paid compensation benefits from May 28 through August 14, 2010.

OWCP referred appellant, along with the medical record and statement of accepted facts (SOAF), to Dr. Aubrey A. Swartz for a second opinion examination to determine whether he continued to suffer residuals of his accepted injuries and whether he remained disabled from work. In an August 30, 2012 report, Dr. Swartz noted that he reviewed the SOAF and provided a history of the January 20 and February 6, 2010 employment injuries. He reviewed appellant's medical treatment, including medical records, and noted that he sustained previous back injuries due to car accidents. Upon physical examination, Dr. Swartz observed tenderness to light fingertip touch over appellant's upper trapezius and tenderness over the lumbar spine and both lateral paraspinous regions. He indicated that appellant was also tender to light touch over the sacrum and both posterior and lateral hips. Dr. Swartz provided range of motion findings for cervical and lumbar spines and bilateral shoulders. Upon examination of the lower extremities, he observed that appellant's reflexes were absent and sensation was intact. Straight leg raise testing revealed pain.

Dr. Swartz diagnosed contusion of the lumbar spine with subsequent imaging findings of spondylolysis at L5, bone spurring at L4 and L5, and disc bulge at L4-5 and L5-S1, left posterolateral disc bulge at L4-5 with associated moderate left neuroforaminal stenosis at L5-S1, and associated left lower extremity radicular complaints. He explained that there were several inconsistencies in the physical examination[2] and no objective evidence of radiculopathy related to appellant's lumbar spine. Dr. Swartz reported that appellant did not continue to suffer residuals of his work-related injuries and was no longer disabled from work as a result of his accepted conditions. He advised that appellant did not need any other pain management except for six physical therapy treatments. Dr. Swartz submitted a work capacity evaluation report.

On January 15, 2013 Dr. Swartz' report was forwarded to appellant's treating physician, Dr. Jonathan Nissanoff, a Board-certified orthopedic surgeon. By letter dated January 7, 2013, Dr. Nissanoff indicated that he had reviewed Dr. Swartz' August 30, 2012 report and disagreed

[2] Dr. Swartz specifically pointed out that there was tenderness to light fingertip touch over appellant's spine form his neck down to his low back and no evidence of spasm. His neurologic examination was normal. Dr. Swartz also indicated that there was marked symptom magnification with straight leg raise testing bilaterally.

with his findings. He asserted that appellant clearly had radicular symptoms of significant chronic pain which was well described in the Official Disability Guidelines (ODG). Dr. Nissanoff explained that although appellant had a preexisting condition, he suffered a direct work-related injury which aggravated his preexisting pathology.

On February 5, 2013 Dr. Roger W. Shortz, a Board-certified neurological surgeon, became appellant's new treating physician and he was also asked to review the report of Dr. Swartz. In reports dated January 15 to July 12, 2013, he noted appellant's complaints of ongoing moderate and severe low back and radicular leg pain. Dr. Shortz reviewed appellant's medical records and diagnostic studies. He related that MRI and CT scans revealed significant pathology consistent with appellant's objective findings of radiculopathy. Dr. Shortz diagnosed lumbar intervertebral disc herniation with foraminal stenosis, L4-5 and L5-S1 with nerve root impingements, bilateral L5 pars defects, foraminal stenosis, and bilateral radiculopathy. He recommended that appellant undergo a bilateral laminectomy and discectomy with facetectomy for nerve root decompression at L4-5 and L5-S1 combined with posterior interbody fusion cages and posterior instrumentation and fusion. Dr. Shortz opined that appellant's present disability and need for treatment were directly related to the January 20 and February 6, 2010 employment injuries. He indicated that at no time since the date of injury had appellant reached maximum medical improvement. Dr. Shortz reported that appellant remained temporarily totally disabled throughout the period from the date of injury through the present date.

On March 5, 2013 OWCP proposed to terminate appellant's medical and wage-loss compensation benefits effective August 30, 2012 based on the report of Dr. Swartz who determined that appellant no longer had a medical condition or disability directly related to his specific employment injuries. It advised appellant that he had 30 days to submit additional evidence or argument.

Dr. Shortz reevaluated appellant on March 8, 2013 and reviewed his request for additional surgery.

On March 20, 2013 appellant underwent another MRI scan examination of the lumbar spine by Dr. Sung. Dr. Sung observed broad-based disc protrusion eccentric to the left at L4-5 causing moderate left neural foraminal stenosis and mild right neural foraminal stenosis, moderate left neural foramina stenosis at L5-S1 due to inferior disc encroachment, and annular fissure within the L4-5 and L5-S1 discs.

On March 25, 2013 OWCP paid compensation benefits for the period August 15, 2010 through April 6, 2013 and was thereafter placed on the periodic rolls.

OWCP determined that a conflict in medical evidence existed between appellant's treating physicians and Dr. Swartz, OWCP's referral physician, regarding whether appellant continued to suffer residuals and remained disabled from work as a result of the January 20 and February 6, 2010 employment injuries. It referred appellant, along with a SOAF and the medical record, to Dr. Anthony Fenison, a Board-certified orthopedic surgeon, and Dr. Lokesh Tantuwaya, a Board-certified neurosurgeon, for impartial medical examinations to resolve the conflict in medical opinion.

In a May 1, 2013 report, Dr. Fenison reviewed appellant's history, including the SOAF, and noted that on January 20, 2010 appellant injured his lower back when a door hit him in the performance of duty. He related that a few weeks later appellant sustained an injury to his chest and back when he fell down after a big wave caused the ship to suddenly shift. Dr. Fenison indicated that appellant's claims were accepted for lumbosacral neuritis of the bilateral lower extremities, acquired lumbar spondylolisthesis, spondylolysis at L5, chest contusion, and lumbar strain. Upon examination of appellant's lumbar spine, he observed diffuse tenderness across the lower back, but no loss of lumbar lordosis. Dr. Fenison indicated that appellant's reactions were out of proportion to the palpation that was being performed and that he demonstrated signs of symptom magnification. He further noted that appellant demonstrated a positive Waddell's sign. Range of motion revealed forward flexion to 30 degrees, extension to 10 degrees, right lateral flexion to 5 degrees, and left lateral flexion to 10 degrees. Straight leg raise testing was negative bilaterally in the seated position. Dr. Fenison reported that x-rays obtained that day revealed degenerative changes and no fractures or dislocations. He reviewed appellant's medical records and provided notations.

Dr. Fenison diagnosed bilateral pars defect (spondylosis) at the L5-S1 level, chronic lumbar spine myofascilitis/sprain/strain, superimposed upon degenerative disc and joint disease, and symptom magnification. He explained that appellant's reactions throughout the examination reflected symptom magnification and the positive Waddell's sign made it somewhat difficult to correlate with any confidence appellant's subjective complaints to the diagnostic studies. Dr. Fenison reported that at this time appellant did not demonstrate any signs or symptoms of radiculopathy and, therefore, his condition had stabilized. He opined that appellant's current pathology would not be related to the two incidents that were noted and the contusion and/or sprain/strain that was caused by the two incidents had resolved. Dr. Fenison indicated that appellant's current symptoms were related to his age and degenerative changes, as well as the acquired pars defect. He explained that appellant's spondylolysis was not related to a work incident and would be considered a preexisting nonindustrial condition. Dr. Fenison did not believe that the "two simple incidents that were described by this patient had any correlation with the patient's documented spondylolysis or mild degenerative changes." He reported that the incidents only caused some soft tissue injuries that resolved some time ago. Dr. Fenison concluded that appellant did not require any additional medical treatment and was no longer disabled as a result of the January 20 and February 6, 2010 employment injuries.

On May 1, 2013 appellant underwent an EMG/NCS examination by Dr. Aaron Coppelson, Board-certified in physical medicine and rehabilitation. Dr. Coppelson reported abnormal NCS due to sensory demyelinating axonal neuropathy. He also noted abnormal EMG for left chronic L5 denervation. Dr. Coppelson indicated that there was no other evidence of peripheral neuropathy or active lumbar radiculopathy in the bilateral lower extremities.

In a June 6, 2013 report, Dr. Lokesh Tantuwaya, a Board-certified neurological surgeon and impartial medical examiner, noted that appellant worked as an able seaman and accurately described the January 20 and February 6, 2010 employment injuries. He indicated that appellant returned to work following the January 20, 2010 employment injury, but had not been able to return to work after the February 6, 2010 injury. Dr. Tantuwaya noted that appellant received extensive conservative treatment, including pain medications, and extensive physical therapy, all without significant relief to his symptoms. He related appellant's present complaints of neck pain that radiated bilaterally down the arms and lower back pain that radiated bilaterally down

the legs. Appellant also described aching, burning, and stabbing sensations in his neck, arms, lower back, and bilaterally in the legs.

Dr. Tantuwaya indicated that he reviewed a plethora of medical records and provided various notations about the records. Upon examination of the cervical spine, he observed no gross anatomical deformities and no significant cervical tenderness to palpation or muscle spasms. Dr. Tantuwaya reported that thoracic spine inspection revealed tenderness and diffuse pain throughout light touch. A lumbar spine inspection revealed tenderness to palpation and diffuse pain throughout to light touch. Dr. Tantuwaya provided cervical and lumbar spine range of motion findings. He reported that straight leg raise testing was negative in the seated position and that appellant was unable to tolerate a straight leg raise test in the supine position bilaterally to greater than 40 degrees due to pain. Upon examination of the upper and lower extremities, Dr. Tantuwaya observed decreased pinprick sensation and decreased sensation. Phalen's and Tinel's signs were negative bilaterally.

Dr. Tantuwaya diagnosed lumbar spondylolysis, chronic lower back pain, type 2 diabetes mellitus, and hypertension. He indicated that appellant's current examination was suggestive of symptom magnification. Dr. Tantuwaya pointed out that the numerous Waddell's signs, nondermatomal sensory loss, multiple myotomal weaknesses, pain upon light touch, and loss of sensation were noted in the clinical examination. He explained that the latter finding could not be caused by a lumbar spine injury. Dr. Tantuwaya further reported that the diagnostic examination did not reveal any significant nerve root compression, vertebral fractures, or lumbar central canal stenosis. He noted that, while there was a finding of bilateral spondylolysis at the L5-S1 level, there was no evidence of spondylolisthesis or lumbar spinal instability. Dr. Tantuwaya concluded that appellant did suffer an industrial injury during his employment but had now reached maximum medical improvement. He noted that appellant also suffered from underlying spondylolysis and had preexisting diabetes and hypertension. Dr. Tantuwaya opined that lumbar surgery was unnecessary and would not improve his employment injuries. He indicated that appellant had a permanent work restriction from performing heavy work.

By letter dated August 1, 2013, OWCP advised Dr. Tantuwaya that although he provided an opinion regarding authorization for surgery he did not provide an opinion on whether appellant continued to suffer residuals and remained disabled as a result of his employment injuries. It requested clarification from Dr. Tantuwaya regarding whether there was objective evidence to support that appellant suffered a permanent aggravation of his preexisting lumbar condition caused by the January 20 and February 4, 2010 employment injuries. No further reports were received from Dr. Tantuwaya.

In reports dated August 9 to October 18, 2013, Dr. Shortz related that appellant continued to complain of moderate-to-severe low-back pain and left, greater than right radicular leg pain. Dr. Shortz reported that neurological examination demonstrated weakness in the left greater than right extensor hallucis longus and gastrocnemius muscles. Sensory examination revealed diminished sensation to light touch over the posterolateral thigh, calf, and foot. Dr. Shortz diagnosed bilateral L5 pars defects, lumbar disc protrusions at L4-5 and L5-S1 with annular tears, foraminal stenosis, and bilateral radiculopathy. He recommended that appellant undergo lumbar surgery as soon as possible. Dr. Shortz opined that appellant had not reached maximum medical improvement and remained temporarily totally disabled throughout the period from the date of injury to the present.

On November 19, 2013 OWCP finalized the termination of appellant's wage-loss compensation and medical benefits effective that day. It determined that the special weight of medical evidence rested with Dr. Fenison's May 1, 2013 report, which determined that his employment-related injuries had resolved.

On November 26, 2013 OWCP received appellant's request for a telephonic hearing before a Branch of Hearings and Review hearing representative.

In January 10 to March 7, 2014 narrative reports, Dr. Shortz related appellant's complaints of moderate-to-severe low back pain and left greater than right radicular leg pain. He reviewed appellant's diagnostic studies and conducted an examination. Dr. Shortz diagnosed bilateral L5 pars defects, lumbar disc protrusions at L4-5 and L5-S1 with annular tears, foraminal stenosis, and bilateral radiculopathy. In the March 7, 2014 report, he related that appellant underwent a new MRI scan of the lumbar spine which revealed a spondylolisthesis and spondylolysis at L5-S1, foraminal stenosis at L4-5. Dr. Shortz opined that appellant had not reached maximum medical improvement and remained temporarily totally disabled throughout the period from the date of injury to present.

A hearing was scheduled for June 17, 2014. Appellant was represented by counsel, who related that appellant was examined by various doctors and eventually referred to an impartial medical specialist. He stated that he asked appellant's physician for a detailed report explaining why appellant was not capable of returning to work. Counsel noted that he would be sending the report to OWCP and alleged that this report should carry the weight of evidence.

Appellant submitted a July 15, 2014 periodic report from Dr. Nissanoff. Dr. Nissanoff related appellant's complaints of moderate-to-severe pain in his lower back. He diagnosed low back pain, lumbar pars defect, herniated disc of the lumbar spine, and radiculopathy of the lower extremities and neuropathic pain.

In an August 29, 2014 narrative report, Dr. Shortz noted that he examined appellant for complaints of ongoing low back pain and bilateral radicular leg pain and numbness. He diagnosed lytic spondylolisthesis, L5-S1 bilateral L5 pars defects, lumbar disc protrusion, L4-5 and L5-S1, with annular tears, foraminal stenosis at L4-5 and L5-S1, bilateral L5-S1 radiculopathy, left greater than right, and lumbar facet arthropathy manifested by facet joint effusions. Dr. Shortz explained that appellant had failed to respond to extensive conservative treatment. He opined that appellant had severe abnormal pathological findings on his MRI scan which were consistent with his complaints and objective findings of radiculopathy on examination. Dr. Shortz recommended that appellant proceed with surgery due to his spondylolisthesis with bilateral pars defect and extensive decompression.

By decision dated September 5, 2014, an OWCP hearing representative affirmed the November 19, 2013 termination decision. She determined that the special weight of medical evidence rested with Dr. Fenison's May 1, 2013 impartial medical report.

On November 24, 2014 appellant underwent L5-S1 lumbar laminectomy and facetectomy with fusion.

On December 19, 2014 OWCP received appellant's request, through counsel, for reconsideration. He noted that he was submitting medical reports that had not previously been

considered and alleged that based on this new evidence OWCP's September 5, 2014 decision should be overturned.

In a December 2, 2014 narrative report, Dr. Nissanoff noted that appellant was one week post L5-S1 fusion and still complained of acute and chronic pain down both legs, with numbness down both legs. He reviewed appellant's history and conducted an examination. Dr. Nissanoff noted that appellant remained disabled.

Dr. Shortz continued to treat appellant and indicated in reports dated December 19, 2014, February 20 and May 29, 2015 that he evaluated appellant for postoperative recovery with mild-to-moderate, intermittent to frequent low back, and bilateral leg pain. He diagnosed status postlaminectomy with instrumentation and fusion. Dr. Shortz reported that appellant was disabled and would most likely reach maximum medical improvement in three to four months.

On March 27, 2015 appellant underwent an MRI scan of the lumbar spine by Dr. Mark S. Schechter, a Board-certified diagnostic radiologist. Dr. Schechter observed satisfactory alignment and no evidence of hardware failure regarding the L5 laminectomy and L5-S1 fusion. He reported that there was no evidence of acute, focal, or paraspinous abnormality.

In a July 29, 2015 report, Dr. Javid Ghandehari, an anthesiologist and pain medicine specialist, indicated that appellant complained of lumbar radicular pain status post L5-S1 effusion. He related that since then appellant had been in a motor vehicle accident. Appellant reviewed his history and conducted an examination. He observed that range of motion was severely limited and that he had a very difficult time walking secondary to severe pain. Dr. Ghandehari indicated that a May 21, 2015 MRI scan of the lumbar spine revealed postoperative appearance for lumbar spine with stable grade 1 anterior listhesis on L5 and S1 with flexion and extension. He recommended that appellant follow up with Dr. Shortz because one of the screws in appellant's spine may need to be removed.

In a decision dated August 19, 2015, OWCP denied modification of the September 5, 2014 decision. It found that the weight of medical opinion rested with Dr. Fenison's May 1, 2013 impartial medical report.

LEGAL PRECEDENT

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.[3] OWCP may not terminate compensation without establishing that the disability had ceased or that it was no longer related to the employment.[4] Its burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[5] The right to medical benefits for an accepted condition is not limited to the period of entitlement for

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

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

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

disability compensation.[6] 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.[7]

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[8] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[9] When there exists opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[10]

ANALYSIS

OWCP accepted that on January 20, 2010 and February 6, 2010 appellant sustained injuries to his lumbar spine and chest in the performance of duty. Appellant's claim was accepted for lumbosacral radiculitis of the bilateral lower extremities, lumbar acquired spondylolisthesis, L5 spondylosis, chest contusion, and lumbar sprain. He stopped work on February 6, 2010 and OWCP paid compensation benefits. In an August 30, 2012 report, Dr. Swartz, an OWCP referral physician, determined that appellant's employment injuries had resolved and that he was no longer disabled from work. In reports dated January 7 and 15, 2013, Drs. Nissanoff and Shortz, appellant's treating physicians, opined that appellant continued to suffer residuals from the work-related injuries and was unable to work. To resolve the conflict between appellant's physicians and the referral physician, OWCP referred appellant to Dr. Fenison for an impartial orthopedic examination, and to Dr. Tantuwaya for an impartial neurologic evaluation. The Board finds that OWCP properly determined that a conflict in medical opinion existed and referred appellant for an impartial medical examinations by Dr. Fenison, a Board-certified orthopedic surgeon, and Dr. Tantuwaya, a Board-certified neurosurgeon.

In a May 1, 2013 report, Dr. Fenison reviewed appellant's history, including the SOAF, and accurately described the January 20 and February 6, 2010 work incidents. Upon examination of appellant's lumbar spine, he observed diffuse tenderness across the lower back but no loss of lumbar lordosis. Dr. Fenison indicated that appellant's reactions were out of proportion to the palpation that was being performed and that he demonstrated signs of symptom

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

[7] *A.P., id.; James F. Weikel*, 54 ECAB 660 (2003); *Pamela K. Guesford*, 53 ECAB 727 (2002).

[8] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

[9] 20 C.F.R. § 10.321.

[10] *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Gloria J. Godfrey*, 52 ECAB 486 (2001).

magnification. He indicated that appellant demonstrated a positive Waddell's sign and that straight leg raise testing was negative bilaterally in the seated position. Dr. Fenison diagnosed bilateral pars defect (spondylosis) at the L5-S1 level, chronic lumbar spine myofascilitis/sprain/ strain, superimposed upon degenerative disc and joint disease, and symptom magnification. He reported that appellant's current symptoms were related to his age and degenerative changes, as well as the acquired pars defect. Dr. Fenison opined that appellant's spondylolysis was not related to a work incident and would be considered a preexisting nonindustrial condition. He explained the incidents only caused some soft tissue injuries that resolved some time ago. Dr. Fenison concluded that appellant did not require any additional medical treatment and was no longer disabled as a result of the January 20 and February 6, 2010 employment injuries. Based on this report, OWCP terminated appellant's wage-loss compensation and medical benefits effective November 19, 2013.

The Board finds that OWCP did not meet its burden of proof to terminate appellant's wage-loss compensation and medical benefits because Dr. Fenison's opinion was not sufficiently rationalized. The Board notes that OWCP accepted that appellant sustained lumbosacral radiculitis of the bilateral lower extremities, lumbar acquired spondylolisthesis, and L5 spondylosis. OWCP instructed Dr. Fenison to determine whether appellant had continuing residuals of his accepted conditions. In spite of the listed accepted conditions, however, Dr. Fenison determined that appellant's spondylolysis was not work related and considered a preexisting condition. He reported that the January 20 and February 6, 2010 employment incidents did not have "any correlation with [appellant's] documented spondylolysis or mild degenerative changes." Instead, Dr. Fenison indicated that the employment incidents "only caused some soft tissue injuries which … did resolve quite some time ago."

In *L.A.*,[11] the Board reversed OWCP's determination terminating appellant's wage-loss compensation and medical benefits because the referee examiner noted that the claimant merely sustained a lumbar sprain and did not acknowledge appellant's accepted conditions of lumbosacral neuritis or radiculitis. OWCP terminated benefits based on the referee examiner's opinion that the lumbar sprain had resolved. Likewise, in this case, Dr. Fenison opined that appellant merely sustained soft tissue injuries as a result of the January 20 and February 6, 2010 employment injuries, instead of the accepted conditions of lumbosacral radiculitis of the bilateral lower extremities, lumbar acquired spondylolisthesis, and L5 spondylosis. It is well established that medical reports must be based on a complete and accurate factual and medical background and that medical opinions based on an incomplete or inaccurate history are of limited probative value.[12] OWCP, therefore, should not have relied on a report that disregarded the accepted conditions as listed.[13] Because Dr. Fenison's May 1, 2013 report was not based on an accurate history, his opinion was not well rationalized and should not be given the special weight of evidence.

[11] Docket No. 14-1138 (issued September 9, 2014).

[12] *J.R.*, Docket No. 12-1099 (issued November 7, 2012); *Douglas M. McQuaid*, 52 ECAB 382 (2001).

[13] *See also C.D.*, Docket No. 08-1266 (issued January 28, 2009) (the Board reversed OWCP's decision terminating appellant's wage-loss compensation and medical benefits where the second opinion examiner determined that the claimant did not sustain the accepted conditions of aggravation of lumbosacral degeneration and aggravation of degeneration of the C4 cervical disc).

The Board also finds that the June 6, 2013 report from Dr. Tanuwaya, who was selected by OWCP to provide an impartial medical neurologic evaluation, was also insufficient to meet OWCP's burden of proof to terminate compensation benefits. As OWCP noted in its August 1, 2013 letter to Dr. Tanuwaya, his report required clarification as it did not sufficiently address the issue of whether appellant remained disabled due to his accepted injuries. The Board has held that once OWCP begins development of the medical evidence, it has the responsibility to obtain an evaluation which will resolve the issue involved in the case.[14]

The Board finds, therefore, that OWCP erred by terminating appellant's compensation effective November 19, 2013. The Board will reverse OWCP's determination terminating appellant's wage-loss compensation and medical benefits.[15]

CONCLUSION

The Board finds that OWCP did not meet its burden of proof to terminate appellant's wage-loss compensation and medical benefits.

ORDER

IT IS HEREBY ORDERED THAT the August 19, 2015 merit decision of the Office of Workers' Compensation Programs is reversed.

Issued: June 3, 2016
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board

[14] *C.K.*, Docket No. 14-1861 (issued January 2, 2015); *see also F.B.*, Docket No. 10-1382 (issued April 13, 2011).

[15] Given the disposition of the first issue, the Board finds that the second issue of continuing disability is moot.