United States Department of Labor
Employees' Compensation Appeals Board

M.C., Appellant	)	
and	)	**Docket No. 17-1417**
	)	**Issued: February 5, 2018**
DEPARTMENT OF THE NAVY, NAVAL SUPPORT FACILITY, Indian Head, MD, Employer	)	

Appearances:
Michael Welsh, for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 13, 2017 appellant, through her representative, filed a timely appeal from a May 22, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). 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.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether OWCP met its burden of proof to terminate appellant's wage-loss compensation effective May 23, 2017.

On appeal appellant's representative asserts that the report of OWCP's referral physician, on which the termination was based, is inconsistent, and that OWCP erred by not contacting the employing establishment to find an appropriate position before terminating appellant's benefits.

FACTUAL HISTORY

On August 27, 1990 appellant, then a 39-year-old contract specialist, filed a traumatic injury claim (Form CA-1) alleging that she injured her back and both legs while moving computer equipment at work on July 6, 1990.[3] She stopped work on the date of injury and did not return. On February 20, 1991 OWCP accepted lumbar strain. It authorized a recommended cervical spine surgery on March 7, 1991.[4]

In April 23, 1991 correspondence, the employing establishment notified OWCP that appellant indicated that she was not going to have the authorized cervical spine surgery, that she was not interested in light duty, and that she was going to move to Florida. The record reveals that by May 1991 appellant had moved from Maryland to Florida. She was terminated due to disability, effective May 15, 1992. OWCP expanded the accepted conditions to include aggravation of lumbar disc herniation at L4-S1 and C6-7 with radiculopathy at C7. Appellant was placed on the periodic compensation rolls.

On January 9, 1997 OWCP additionally accepted depression, single episode, resolved, based on a March 1, 1996 second opinion evaluation of Dr. Richard J. Daly, a Board-certified psychiatrist. Appellant remained on the periodic compensation rolls.

In a January 22, 2008 report, Dr. William Dinenberg, a Board-certified orthopedic surgeon and OWCP referral physician, diagnosed chronic cervical and lumbar spine pain and lumbar and cervical herniated disc. Dr. Dinenberg advised that, while the accepted conditions had not resolved, appellant could perform sedentary work.

In June 2008 appellant began seeing Dr. Raul F. Nodal, a neurosurgeon.

OWCP continued to develop the claim. In August 2008 it referred appellant to Dr. James R. Edgar, a Board-certified psychiatrist. In a September 30, 2008 report, Dr. Edgar indicated that appellant had no diagnosed medical condition and advised that she could return to her usual job. In June 2009 OWCP referred appellant to Dr. James P. Ryan, IV, Board-certified in orthopedic surgery. In a July 29, 2009 report, Dr. Ryan advised that the employment injuries

[3] The record also indicates that appellant was in a motor vehicle accident in 1986 that was not employment related. This resulted in a 1988 lumbar laminectomy.

[4] An October 15, 1990 magnetic resonance imaging (MRI) scan of the cervical spine demonstrated a herniated disc at C6-7. On October 30, 1990 Dr. Arthur Litofsky, an attending Board-certified neurosurgeon, requested that cervical surgery be authorized.

had resolved and that she could perform the sedentary duties of the contract specialist position.[5] A July 21, 2010 lower extremity electrodiagnostic study was consistent with bilateral L5 and S1 radiculopathy.

In a May 13, 2011 report, Dr. Nodal advised that appellant had continued neck and low back pain. He diagnosed failed back surgery in 1988, aggravated by the 1990 employment injury, with chronic pain syndrome and multilevel spondylosis of the cervical spine causing moderate-to-severe spinal canal stenosis at C6-7. Dr. Nodal recommended a functional capacity evaluation (FCE) to assess appellant's work ability. By letter dated July 6, 2012, appellant notified OWCP that Dr. Nodal had died in a motor vehicle accident. In a July 10, 2012 report, Dr. Diane D. Zhao, a Board-certified physiatrist, diagnosed chronic low back pain with lumbar radiculopathy, status post lumbar laminectomy, and chronic neck pain.

In December 2013 Dr. Robert Reppy, an osteopath who practices family medicine, began treating appellant. In reports dated December 17, 2013, July 14, 2014, and May 27, 2015, he noted complaints of neck and low back pain. Physical examination demonstrated decreased cervical and lumbar range of motion. Dr. Reppy diagnosed cervical disc disease with radiculopathy, severe stenosis at C6-7, status post lumbar laminectomy, bulging discs at L4-5 and L5-S1, and generalized anxiety and panic attacks. A July 9, 2015 MRI scan of the lumbar spine demonstrated disc bulges at L2-3, L3-4, L4-5, and L5-S1, with the latter touching the exiting nerve roots.

In a September 30, 2015 narrative report, Dr. Reppy maintained that the accepted conditions should be lumbar disc disease at L4-5 and L5-S1, lumbar stenosis at L4-5, status post lumbar laminectomy, cervical disc disease with radiculopathy of the upper extremities, and severe stenosis at C6-7, which caused continuing symptoms and had not resolved. He requested a psychiatric consultation to address appellant's depression and anxiety. Dr. Reppy advised that appellant had limited work ability because she could only carry objects weighing less than 10 pounds, could only walk short distances, and had a phobia about driving, noting that her depression would affect her ability to work. He concluded that appellant could perhaps work from home for a few hours daily. Dr. Reppy did not think pain management or vocational rehabilitation would be successful. He continued to treat appellant on a regular basis.

In August 2016 OWCP referred appellant to Dr. Dinenberg. In a September 19, 2016 report, Dr. Dinenberg noted the history of injury, appellant's description of her medical care, and her report that she was seeing a doctor for depression and that she had suffered two strokes. He noted her past medical history including a lumbar laminectomy following a motor vehicle accident and his review of the medical record. Dr. Dinenberg indicated that appellant had a nonantalgic gait and used no canes, crutches, or walker. Examination indicated venous stasis changes on both lower extremities with decreased sensation circumferentially in a stocking distribution beginning at the level of the mid thighs and extending to her feet bilaterally. Straight-leg raising and bowstring examinations were negative bilaterally. Due to appellant's

[5] A copy of the position description indicates that the position is primarily sedentary with occasional walking, standing, bending, carrying light items such as reports or files, and driving an automobile. On April 23, 2010 OWCP proposed to terminate appellant's wage-loss compensation and medical benefits based on Dr. Ryan's opinion. The proposed termination was not finalized by OWCP.

complaint that any flexion or extension caused pain, he discontinued lumbar range of motion examination. Cervical spine range of motion was diminished. Appellant was tender to palpation in the paraspinous region of the lower cervical spine and in the trapezial region. Biceps, triceps, and deltoid strength, and motor strength in wrist flexion and extension, and finger abduction and grip were 5/5. Dr. Dinenberg diagnosed administratively accepted lumbar sprain, resolved; administratively accepted aggravation of lumbar herniated disc at L4 through S1 with subjective complaints of bilateral lower extremity radiating pain, left greater than right; and administratively accepted herniated nucleus pulposus of cervical spine at C6-7. In response to OWCP questions, he indicated that objective findings included nonphysiologic numbness in a stocking distribution in the legs, MRI scan findings of a central disc bulge/protrusion at the L4-5 level, which contacted the exiting nerve roots in the neural foramina, diminished lumbar range of motion secondary to complaints of pain, and diminished cervical spine range of motion with a large C6-7 disc herniation, as shown on a 1990 cervical MRI scan.

Dr. Dinenberg advised that the accepted lumbar sprain/strain had resolved and that the lumbar disc bulge seen on MRI scan had not resolved. Although appellant complained of bilateral radicular symptoms, this was subjective and not objectively seen. Dr. Dinenberg noted that, while he did not have a recent cervical spine MRI scan for review, he anticipated that the large herniated disc at the C6-7 level remained present. He advised that appellant had not returned to preinjury status, but that she could perform modified duties with lifting, pushing, and pulling limited to 20 pounds, with seldom bending, kneeling, climbing, or crawling, and that she had the ability to sit, stand, and walk as needed. Dr. Dinenberg related that appellant had significant difficulty with her memory throughout his history taking and noted her report that this has been a problem since 2004. He further noted that the medical records indicated a diagnosis of depression, and she had a very depressed affect and was tearful throughout his evaluation and indicated that restrictions for these were outside the scope of his orthopedic practice. Dr. Dinenberg concluded that no further treatment was indicated for the cervical or lumbar spine and, given the absence of work activity for the last 26 years, it was doubtful that she would return to productive suitable employment. In an attached work capacity evaluation, he advised that appellant had permanent restrictions of one-hour twisting, bending, squatting, kneeling, and climbing, and could push, pull, and lift 20 pounds for three hours.

Dr. Reppy submitted follow-up evaluations on September 8, October 6, and December 15, 2016. He provided findings and reiterated his diagnoses with the addition of generalized depression, unresolved grief, and situational anxiety.

On February 1, 2017 OWCP proposed to terminate appellant's wage-loss compensation. It found that the weight of the medical opinion rested with Dr. Dinenberg who advised that, while appellant continued to have residuals of the accepted conditions, she could perform sedentary duty such as her date-of-injury job as a contract specialist. As such, appellant was no longer disabled from work due to the July 6, 1990 employment injury.

Appellant disagreed with the proposed termination, and on March 1, 2017 authorized representation. In a report dated February 15, 2017, Dr. Reppy advised that appellant could attempt to return to work a trial basis. He ordered an FCE. The FCE, done on February 16, 2017, demonstrated diminished cervical and lumbar range of motion, and diminished grip and

pinch strength. On February 22, 2017 Dr. Reppy noted the results of the FCE and reiterated his diagnoses.

In an undated pleading, appellant's representative noted his disagreement with the proposed termination. He related that appellant tried to return to work in 1991, but the employing establishment would not let her and that she and her husband had a small cattle ranch which they worked themselves. The representative maintained that appellant had had two strokes and was not medically able to return to work. He also referenced medical evidence not in the record regarding appellant's cervical spine condition. In March 2, 2016 correspondence, the representative asserted that the condition of depression had not resolved and should be accepted.

On March 30, 2017 OWCP received a March 27, 2017 report in which Dr. Gillian Karatinos, a Board-certified psychiatrist, reviewed some medical evidence and noted chief complaints of depression and back pain. Dr. Karatinos related that appellant was a difficult historian with poor memory and that she was extremely obese. She noted appellant's report that she was unable to tolerate prescription drugs based on bad reactions to two medications and that, although she reported having a stroke, there was no medical evidence of record supporting this fact. Dr. Karatinos performed a number of tests and diagnosed major depressive disorder, recurrent, severe without psychosis, persistent depressive disorder, generalized anxiety disorder, mild neurocognitive disorder due to multiple medical etiologies, probable dysautonomia, hypertension, obesity, and probable untreated hypothyroidism. In an April 23, 2017 letter, she reiterated that appellant was a poor historian, noting bad memory due to a possible previous stroke as well as due to the cognitive effects of her diagnoses including major depressive disorder, persistent depressive disorder, chronic pain, and aging. Dr. Karatinos concluded, "It would appear that most of her current diagnoses are related directly or indirectly to her original injury based on her history."

In an April 4, 2017 report, Dr. Reppy repeated his findings and conclusions.

By decision dated May 4, 2017, OWCP terminated appellant's wage-loss compensation, effective May 5, 2017. It noted that Dr. Karatinos' opinion on causal relationship of additional medical conditions was speculative. OWCP found the weight of the evidence rested with the opinion of Dr. Dinenberg. It also noted that, as there was no evidence that the representative was authorized, his pleading would not be considered.

On May 9, 2017 the representative wrote OWCP, asserting that he was qualified to present evidence on appellant's behalf as an agent of his employer.

On May 22, 2017 OWCP determined that appellant's representative was qualified to represent her and therefore vacated the May 4, 2017 decision. Appellant's wage-loss compensation was reinstated effective May 5, 2017.

In a second May 22, 2017 decision, OWCP reviewed the representative's response to the notice of proposed termination. It again noted that Dr. Karatinos' opinion was speculative and found the weight of the evidence rested with the opinion of Dr. Dinenberg. OWCP terminated appellant's wage-loss compensation benefits, effective May 23, 2017.

LEGAL PRECEDENT

Once OWCP accepts a claim and pays compensation, it has the burden of proof to justify modification or termination of an employee's benefits. It may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.[6] OWCP's burden of proof in terminating compensation includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[7]

Under FECA the term "disability" means the incapacity, because of an employment injury, to earn the wages that the employee was receiving at the time of injury. Disability is thus not synonymous with physical impairment, which may or may not result in an incapacity to earn wages. An employee who has a physical impairment causally related to a federal employment injury, but who nevertheless has the capacity to earn the wages he or she was receiving at the time of injury, has no disability as that term is used in FECA.[8] Furthermore, whether a particular injury causes an employee to be disabled for employment and the duration of that disability are medical issues which must be proved by a preponderance of the reliable, probative and substantial medical evidence.[9]

ANALYSIS

OWCP accepted appellant's traumatic injury claim for lumbar strain, aggravation of lumbar disc herniation at L4-S1, and C6-7 with radiculopathy at C7. On January 9, 1997 it additionally accepted depression, single episode, resolved.

The medical evidence relevant to the May 23, 2017 termination of wage-loss compensation included Dr. Dinenberg's comprehensive September 19, 2016 report. He noted the history of injury, appellant's complaint of back and neck pain, and his review of the medical record. Following a thorough examination, Dr. Dinenberg advised that the accepted lumbar sprain/strain had resolved and that the lumbar disc bulge and herniated disc at C6-7 remained present, but had not yet resolved. He added that appellant's complaint of bilateral radicular symptoms was subjective with no objective support. Dr. Dinenberg advised that, while appellant had not returned to preinjury status, she could perform modified duties. He limited lifting, pushing, and pulling to 20 pounds, with seldom bending, kneeling, climbing, crawling, and advised that appellant should have the ability to sit, stand, and walk on an as needed basis. Dr. Dinenberg opined that no further treatment was indicated for the cervical or lumbar spine. He noted that appellant had significant difficulty with her memory throughout his history taking and that the medical records indicated a diagnosis of depression, which was outside the scope of his expertise. Dr. Dinenberg concluded that, while appellant continued to have residuals of the employment injuries, she could return to the sedentary position as a contract specialist.

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[6] *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[7] *Id.*

[8] *See* 20 C.F.R. § 10.5(f); *Cheryl L. Decavitch*, 50 ECAB 397 (1999).

[9] *Fereidoon Kharabi*, 52 ECAB 291 (2001).

Dr. Reppy, appellant's attending osteopath, maintained on September 30, 2015, that additional conditions should be expanded to include lumbar disc disease at L4-5 and L5-S1, lumbar stenosis at L4-5, status post lumbar laminectomy, cervical disc disease with radiculopathy of the upper extremities, and severe stenosis at C6-7, which caused continuing symptoms and had not resolved. He also advised that appellant had limited work ability because she could only carry objects weighing less than 10 pounds, could only walk short distances, and had a phobia about driving, noting that her depression would affect her ability to work. On February 15, 2017 Dr. Reppy advised that appellant could attempt to return to work on a trial basis.

In a March 27, 2017 report from Dr. Karatinos it was noted that appellant had reported that she suffered a stroke. Dr. Karatinos performed a number of tests and offered diagnoses that included major depressive disorder, recurrent, severe without psychosis, persistent depressive disorder, generalized anxiety disorder, and mild neurocognitive disorder due to multiple medical etiologies. He also indicated that it would appear that most of appellant's current diagnoses were related directly or indirectly to her original injury, based on her history.

The Board finds that the record contains no medical evidence to indicate that appellant suffered a stroke or strokes. Her current emotional condition/status has not been accepted. As noted, while OWCP accepted depression, single episode, on January 9, 1997, it subsequently found that the condition had resolved. Moreover, Dr. Karatinos' report is couched in speculative terms. The Board has long held that medical opinions that are speculative or equivocal in character have little probative value.[10]

Furthermore, the additional conditions noted by Dr. Reppy have not been accepted. As OWCP has not accepted the additional conditions, appellant has the burden of proof to establish an employment connection.[11] This she has not done.

Dr. Dinenberg provided a well-rationalized opinion explaining that appellant's employment-related condition had resolved and that she had no employment-related disability. It, thus, represents the weight of the medical evidence at the time OWCP terminated appellant's wage-loss compensation. Dr. Dinenberg had full knowledge of the relevant facts and evaluated the course of appellant's accepted conditions. His opinion was based on proper factual and medical history and his report contained a detailed summary of this history. Dr. Dinenberg addressed the medical record and made his own examination findings to reach a reasoned conclusion regarding appellant's conditions.[12] Dr. Dinenberg found no basis on which to attribute any continued disability to the accepted conditions. Appellant's date-of-injury position as a contract specialist was sedentary.[13] Dr. Dinenberg indicated that appellant could perform

[10] *T.M.*, Docket No. 08-0975 (issued February 6, 2009).

[11] *See supra* note 6.

[12] *See Michael S. Mina*, 57 ECAB 379 (2006) (the opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion are facts, which determine the weight to be given to each individual report).

[13] *Supra* note 5.

sedentary duties. His opinion is found to be probative evidence and reliable, and sufficient to justify OWCP's termination of wage-loss compensation due to the accepted July 6, 1990 injury.[14]

CONCLUSION

The Board finds that OWCP met its burden of proof to terminate appellant's wage-loss compensation effective May 23, 2017.

ORDER

IT IS HEREBY ORDERED THAT the May 22, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 5, 2018
Washington, DC

Christopher J. Godfrey, Chief 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] *Supra* note 6.