United States Department of Labor
Employees' Compensation Appeals Board

L.H., Appellant	)	
	)	**Docket No. 17-1859**
and	)	**Issued: May 10, 2018**
	)	
U.S. POSTAL SERVICE, POST OFFICE, Bellmawr, NJ, Employer	)	

Appearances:
Aaron B. Aumiller, Esq., 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 August 28, 2017 appellant, through counsel, filed a timely appeal from a March 1, 2017 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 December 23, 2014; and (2) whether appellant

[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.

met her burden of proof to establish continuing employment-related disability after December 23, 2014.

On appeal counsel contends that OWCP's decision is erroneous as it is based on flawed findings of fact and mistaken conclusions of law. He asserts that OWCP disobeyed its procedures, noting that appellant's treating physicians are better qualified than OWCP's referral physician to render an opinion regarding the causal relationship between appellant's rheumatoid arthritis condition and the accepted employment-related condition. Counsel further asserts that the medical report of OWCP's referral physician is not entitled to the weight of the medical evidence as it contains inconsistencies while the treating physicians' opinions are well rationalized. He contends that at the very least, appellant should have been referred to a referee physician to resolve a conflict in medical opinion between her physicians and OWCP's referral physician, prior to the termination of her compensation benefits.

FACTUAL HISTORY

On December 18, 2004 appellant, then a 43-year-old mail processor, filed a traumatic injury claim (Form CA-1) alleging that on that day she developed lower left back pain as a result of lifting mail out of containers and placing it onto a ledge. She stopped work on the date of injury and has not returned to work.

On February 1, 2005 OWCP accepted the claim for herniated disc at L5-6. It paid compensation benefits on the supplemental rolls from February 19 to March 18, 2005. OWCP authorized intraoperative fluoroscopy performed on August 9, 2005 by Dr. Vincent M. Padula, a Board-certified anesthesiologist. Appellant received compensation benefits for temporary total disability on the periodic rolls as of April 17, 2005.

Appellant continued to receive medical treatment and was authorized by OWCP to undergo thoracic spinal cord stimulator trial (advanced bionic octrode) performed by Dr. Dajie Wang, a Board-certified anesthesiologist, on September 22, 2008.

On November 5, 2010 OWCP referred appellant, together with a statement of accepted facts (SOAF), the medical record, and a list of questions, to Dr. Lawrence I. Barr, a Board-certified orthopedic surgeon, for a second opinion to determine whether she continued to have residuals and disability due to the accepted employment-related condition. In a November 24, 2010 medical report, Dr. Barr examined appellant and provided an impression of degenerative disc disease of the lumbar spine. He opined that no actual work injury occurred and thus, there was no causal relationship between her condition and her federal employment. Dr. Barr reasoned that appellant was merely performing her regular job duties on December 18, 2004 and there was no incident. He maintained that her leg just gave out. Dr. Barr further reasoned that appellant had a normal electromyogram (EMG) and there was no nerve compression. He permanently restricted her to performing sedentary work only. Dr. Barr recommended that appellant undergo a functional capacity evaluation (FCE) to determine her actual capabilities and the work duties she could perform.

On August 16, 2011 Cynthia Bilicki Nimz, a doctor of physical therapy, conducted an FCE. She noted that appellant could perform sedentary work with certain restrictions eight hours a day,

40 hours a week. Ms. Nimz further noted that she may require breaks/changing of positions as needed due to reported discomfort from sitting or standing too long.

On July 9, 2014 OWCP received a copy of the employing establishment's June 16, 2014 offer for a full-time modified position accepted and signed by appellant on July 1, 2014. On July 29, 2014 appellant advised OWCP that she had not returned to work. She claimed that she never accepted the employing establishment's job offer.

On September 30, 2014 OWCP referred appellant, together with a SOAF, the medical record, and a list of questions, to another second opinion physician, Dr. Stanley R. Askin, a Board-certified orthopedic surgeon, to determine whether she continued to have residuals and disability due to the accepted work injury. In an October 17, 2014 report, Dr. Askin reviewed the SOAF and medical record. On physical examination, he reported that appellant was a well-developed and well-nourished lady and in no distress. Dr. Askin indicated that her reported area of back pain took up most of the lumbosacral spine area. Despite the reported pain, he noted that there was no spasm of the paravertebral muscles. Appellant had 70 degrees of forward flexion and 15 degrees side bending to each side. There was no tenderness at the greater trochanters or the sciatic notches. Calf circumferences measured 38 centimeters equally. Muscle function of the hip abductors, hip adductors, hip flexors, hip extensors, quadriceps, hamstrings, and ankle and toe motors were normally contractile. Straight leg raising was permitted to 90 degrees for each leg without a report of radicular pain, but there was a pulling sensation in the upper posterior thigh and buttock area. Deep tendon reflexes at the knees and ankles were symmetrical. Sensation was preserved to light touch about both lower extremities. Dr. Askin related that of incidental note, appellant's knees appeared visibly widened, but they were not tender to touch. Both knees had audible and palpable retropatellar crepitance on motion. Dr. Askin reviewed a February 14, 2008 lumbar magnetic resonance imaging (MRI) scan which revealed disc bulging that was most significant at L1-2 and L2-3 and desiccation of the L5-S1 disc.

Dr. Askin noted that although he was bound by the SOAF, the accepted diagnosis was of historical utility only. He related that appellant had rheumatoid arthritis, a condition perfectly capable of causing back pain, and there was no reason why this condition could not explain her back pain complaints. Dr. Askin furthermore related that even apart from her rheumatologic condition, she was at an age when run-of-the-mill degenerative disc disease was frequently the best explanation for back pain. He maintained that the bottom line was that the medical basis of appellant's back pain was either due to her degenerative disc disease and/or rheumatologic condition. Dr. Askin noted that there was no objective finding of any compensable condition. He found that appellant's injury-related condition had resolved. Dr. Askin also found that she did not continue to suffer from any disabling residuals or lingering effects of her work injury. There was no clinical finding to support continuation of appellant's accepted work injury.

Dr. Askin advised that he had no injury-related reason to preclude her return to full-duty work. He related that if appellant perceived that she was incapable of working due to her nonwork-related conditions that was a separate issue. Dr. Askin further related that he did not dispute that pain may have been associated with the activity described, but it was merely a temporary expression of discomfort. Lingering complaints of pain so many years later could not be on the basis of that singular event. He noted that was not the nature of an injury, but rather a disease. Dr. Askin noted that in this respect, the FCE indicated that appellant had some limitations that

might be accommodated and appeared to subsume her nonwork-related problem, which again included the degenerative disc condition and/or rheumatologic problem. He maintained that the fact that she smoked could also be understood to be a potential hindrance for performing physically demanding activities, which was not work related. Dr. Askin noted that there was no indication for further medical treatment since 2011 and that was also appellant's history. She did not require any medical care for her work-related injury. Dr. Askin related that spinal cord stimulators were not efficacious in restoring function. They addressed pain which was a nebulous process not generally responsive to the proposed management. Alternatively, spinal cord stimulation routinely failed to improve capability for activity.

Dr. Askin advised that appellant would not benefit from any other diagnostic testing or treatment related to her work-related injury at that time. He related that certainly, she should remain under the care of her rheumatologist for her rheumatologic condition. Dr. Askin advised that weight loss and discontinuation of smoking would improve her condition. Regarding appellant's ability to return to full-time work without restrictions due to her other conditions, he noted that her baseline degenerative disc disease and rheumatoid arthritis could contribute to perceptions of musculoskeletal discomfort with exertion. Dr. Askin related that limitations which were routinely imposed for musculoskeletal disorders were not necessary because there would be harm to appellant if exertion was permitted. He maintained, however, that it was permissible for a person to work despite having discomfort. Dr. Askin determined that appellant had attained maximum medical improvement (MMI) from her work-related injury. He indicated that a firm diagnosis for her present condition was degenerative disc disease and rheumatoid arthritis. Dr. Askin concluded that appellant would not benefit from another FCE given that she did not benefit from the first FCE. He further concluded that work hardening programs were unlikely to be effective in addressing her complaints. In an October 17, 2014 work capacity evaluation (Form OWCP-5c), Dr. Askin noted that appellant could perform her usual job with no restrictions.

On November 19, 2014 OWCP provided appellant with a notice of proposed termination of her wage-loss compensation and medical benefits because she was no longer disabled due to her accepted employment-related injury. It determined that the weight of the medical evidence rested with the October 17, 2014 report of Dr. Askin. Appellant was afforded 30 days to submit additional evidence or argument.

Appellant submitted a November 24, 2014 report from Dr. Young J. Lee, an attending Board-certified anesthesiologist, in support of her claim. In this report, Dr. Lee examined appellant and assessed annular tear at L5-S1 and disc herniation at L5-S1 based on MRI scans, clinical lumbar radiculopathy, muscle spasm, and chronic pain syndrome due to trauma. He advised that she developed these conditions after her December 18, 2004 work-related injury. Dr. Lee referred appellant to a neurologist and ordered an additional lumbar MRI scan and lower extremity EMG study to address her lower back pain and radicular symptoms in her lower extremity and to determine the type of pain management treatment needed. He determined that she had not yet reached MMI. Dr. Lee concluded that appellant was permanently and totally disabled.

In a report dated December 3, 2014, Dr. Lee indicated that he reviewed Dr. Askin's October 17, 2014 report and disagreed with Dr. Askin's conclusion that appellant no longer had any residuals or disability causally related to her December 18, 2004 employment injury. He noted

appellant's prior visit to his office on November 24, 2014 regarding her low back pain caused by the accepted work-related injury. Dr. Lee further noted a history of appellant's medical treatment which failed to relieve her low back pain. He indicated that a January 11, 2005 lumbar spine MRI scan did not show degenerative changes, but it showed a L4-5 disc bulge, a L5-S1 disc herniation, an annular tear, and an effacing thecal sac. Dr. Lee maintained that while Dr. Askin attributed appellant's low back pain to underlying rheumatoid arthritis, there was no prior history of low back pain. He noted that prior to the December 18, 2004 employment injury she was able to perform her mail processor activities with no restrictions.

Dr. Lee advised that there was a relationship between appellant's workers' compensation injury and current low back pain. He indicated that an annular tear was a rip in the annulus fibrous, a tough ring that surrounded each intervertebral disc. The most likely mechanism began with aberrant mechanical forces causing an inflammatory response and thus stimulating the nociceptive receptors within the disc (*i.e.*, bending to pick up mail out of containers). Pure discogenic pain was not possible until the nucleus pulposus disrupted the outer annular fibers. This phenomenon occurred with bulging or herniation of the disc when there was trauma to the back. Three factors were involved in the evolution of discogenic pain, structural disruption of the disc, inflammatory infiltration to the site of disruption, and nociceptive sensitization at the level of the discs innervation. Trauma to the spinal cord would create such a reaction, thus causing the chronic low back pain that appellant experienced. Dr. Lee opined that based on a reasonable degree of medical probability, current medical findings, pertinent historical data, and documentation there was causation between the work-related injury and appellant's current medical condition as she did not have a history of low back pain until after the injury in question.

Dr. Lee noted that although there was a medical history of rheumatoid arthritis, it could not be concluded that this was the main cause of appellant's pain. He further noted that Dr. Askin did not reference any medical records prior to the injury in question as proof that the L5-S1 disc herniation and annular tear were degenerative disorders. Dr. Lee related that in fact, all the medical records pointed directly to traumatic injury as the cause of appellant's lumbar spine conditions post December 18, 2004. He also related that even if she had underlying rheumatoid arthritis she was not symptomatic at the time of injury. Dr. Lee maintained that the work-related injury may have aggravated the dormant condition and caused it to surface. He noted that rheumatoid arthritis symptoms come and go depending on the degree of tissue inflammation. When body tissues are inflamed (*i.e.*, after trauma occurred), the disease becomes active. When tissue inflammation subsides, the disease goes into remission. The course of rheumatoid arthritis varied among affected individuals and periods of flares and remissions were typical. It was not uncommon for a patient that suffered from rheumatoid arthritis to flare up after a trauma. When the disease was active symptoms could include fatigue, loss of energy, lack of appetite, low-grade fever, muscle and joint aches, and stiffness. Muscle and joint stiffness were usually most notable in the morning and after periods of inactivity. During flares, joints frequently became warm, red, swollen, painful, and tender. Rheumatoid arthritis usually inflamed multiple joints and affected both sides of the body. Chronic inflammation could cause damage to body tissues, including cartilage and bone. Dr. Lee maintained that this would lead to a loss of cartilage and erosion of the bones and muscles resulting in joint deformity, destruction, and loss of function. He noted that none of these symptoms explained appellant's pain. He further noted that although rheumatoid arthritis could be found in the spine, not one of appellant's medical records pointed to the fact that her rheumatoid arthritis was active or that any degenerative or arthritic conditions were found in imaging or

diagnostic studies performed directly after the injury. Dr. Lee advised that the subjective and objective evidence found on examination did not lead him to believe that her pain was caused by an arthritic condition. He indicated that Dr. Askin's examination revealed that appellant's knees "appear visibly widened" and "crepitance on motion." These were clearly indications that her rheumatoid arthritis was active. However it did not mean that the disease was attacking appellant's spine.

Dr. Lee related that Dr. Askin also noted that appellant's age was a factor in her pain, but however, indicated that again no degenerative changes were noted on any diagnostic imaging. He noted Dr. Askin's finding that her age could be a factor causing her pain today, but indicated that again no diagnostic testing showed degenerative changes. Dr. Lee also noted his finding that the accepted injury could not be causing appellant's current pain as it occurred over a decade ago. He maintained, however, that it was common for patients with spinal injuries such as appellant to be symptomatic for the rest of their lives. A herniated disc in the low back may cause the following symptoms, low back pain, muscle tightness and cramping (which was positive on Dr. Askin's examination), pain that radiated down the leg, and tingling in the legs and/or feet with weakness. To state that appellant was experiencing pain due to her age and underlying condition of rheumatoid arthritis showed an incredible lack of attention to her medical record and current medical criteria needed to meet each diagnosis. Dr. Lee reiterated that she had not reached MMI. He determined that appellant remained symptomatic and would remain symptomatic for the rest of her life. Dr. Lee concluded that the work-related lumbar injury caused her lumbar spine to weaken and would never heal normally. This was a permanent loss of a body function. Dr. Lee further concluded that appellant needed further medical attention including MRI scan studies, EMG lower extremities studies, and possible interventional pain management to relieve her low back pain. He respectfully requested that OWCP overturn its decision denying her care and fully reinstate her benefits.

Appellant also submitted a November 26, 2014 lumbar MRI scan report from Dr. Scott G. Mattox, a Board-certified radiologist, who found significant interval progression of degenerative change at the L4-5 interspace with interval development of moderate acquired spinal stenosis.

In a report dated November 26, 2014, Dr. Russell I. Abrams, a neurologist, indicated that appellant was involved in a work-related incident on December 18, 2004. He related that she presented with low back pain, numbness in both lower extremities, pain shooting down both legs, and weakness in both legs. Dr. Abrams noted appellant's medical, social, and family history. He provided a review of systems and findings on physical and neurological examination. Dr. Abrams also provided a clinical impression of lumbar radiculopathy. He opined that it was clear that the above diagnosis was directly related to her December 18, 2004 work-related injury. Dr. Abrams advised that an EMG/nerve conduction velocity (NCV) study of the lower extremities was indicated and medically necessary to differentiate lumbar radiculopathy from a peripheral mononeuropathy.

OWCP received an October 3, 2014 Form OWCP-5c from Dr. Lee indicating that appellant was not capable of performing her usual job due to a L5-S1 annular tear, severe low back pain, and bilateral lower extremity weakness. He further indicated that she could not work eight hours a day with restrictions. Dr. Lee noted that appellant had severe pain with walking, standing, sitting, bending, squatting, and climbing.

OWCP issued a proposed notice of termination on November 19, 2014, finding that the weight of the medical evidence rested with the opinion of Dr. Askin and established that appellant had no disability or residuals causally related to the accepted December 18, 2014 employment injury. It allotted appellant 30 days within which to submit any contrary medical evidence prior to the finalization of the proposed termination of his wage-loss compensation and medical benefits.

Subsequently, OWCP received a supplemental opinion from Dr. Lee. Based on his November 24, 2014 examination and review of medical records, he again opined that appellant was permanently disabled due to her accepted December 18, 2004 employment injury.

By decision dated December 23, 2014, OWCP terminated appellant's medical benefits and wage-loss compensation effective that day. It found that the weight of the medical evidence rested with Dr. Askin who reported that she no longer had any residuals or disability stemming from the accepted employment injury.

OWCP received an additional report dated December 22, 2014 from Dr. Lee who examined appellant, reviewed diagnostic test results, and assessed lumbar radiculopathy at bilateral L4-5 based on an EMG study. He restated his prior assessments of annular tear at L5-S1, disc herniation at L5-Sl, muscle spasm, and chronic pain syndrome due to trauma. Dr. Lee again advised that appellant developed the diagnosed conditions following her December 18, 2004 work-related injury and that she had not reached MMI and was permanently and totally disabled.

In a letter dated January 5, 2015 and received by OWCP on January 9, 2015, appellant, through counsel, requested a telephone hearing with an OWCP hearing representative regarding the December 23, 2014 termination decision.

OWCP received an additional report dated December 10, 2014 from Dr. Abrams and reports dated January 19 to July 24, 2015 from Dr. Lee who reiterated their prior lumbar diagnoses and opinions that the diagnosed conditions were causally related to the accepted December 18, 2004 work injury. Dr. Lee, in reports dated February 18 and May 13, 2015, indicated that he performed a caudal epidural steroid injection under fluoroscopic guidance to treat appellant's lumbar herniated nucleus pulposus with radiculopathy.

By decision dated September 3, 2015, an OWCP hearing representative affirmed the December 23, 2014 termination decision. The hearing representative found that the medical evidence submitted was insufficient to outweigh the weight accorded to Dr. Askin's medical opinion.

OWCP received reports dated September 21 and November 9, 2015 and January 4, 2016, from Dr. Lee who examined appellant and diagnosed sacroiliitis. Dr. Lee reiterated his prior lumbar diagnoses and opinions on causal relationship and appellant's disability status.

In a letter dated August 19, 2016 and received by OWCP on August 24, 2016, appellant, through counsel, requested reconsideration of the September 3, 2015 decision. Counsel contended that OWCP disobeyed its procedures regarding the expertise of Dr. Joshua B. Sundhar, a Board-certified internist, Dr. Lee, Dr. Christopher Kepler, a Board-certified orthopedic surgeon, and Dr. Abrams who were better qualified than Dr. Askin to render an opinion regarding the causal relationship between appellant's rheumatoid arthritis condition. He further contended that

Dr. Askin's medical report was not entitled to the weight of the medical evidence as it contained inconsistencies while the treating physicians' opinions were well rationalized. Counsel asserted that, at the very least, appellant should have been referred to a referee physician to resolve a conflict in medical opinion between Dr. Sundhar and Dr. Lee prior to the termination of her compensation benefits.

In support of her request for reconsideration, appellant submitted a May 25, 2016 report from Dr. Lee who restated his prior lumbar diagnoses and opinion on causal relationship. Dr. Lee noted that appellant's conditions were permanent.

In a November 23, 2015 operative report, Dr. Kepler provided a preoperative and postoperative diagnosis of lumbar stenosis and spondylolisthesis. He indicated that on November 16, 2015 he performed posterior lumbar decompression and instrumented fusion at L4-5.

By letter dated May 20, 2016, Dr. Sundhar noted a history of injury that appellant was at work in 2004 when she experienced pain on the left side of her lower back and left leg. He reviewed a lumbar MRI scan which showed a herniated disc at L4-5. Dr. Sundhar indicated that appellant was subsequently unable to work and she had been under his care for rheumatoid arthritis. He advised that there was no spinal involvement of her rheumatoid arthritis or extra-articular manifestations. Dr. Sundhar opined within a reasonable degree of medical certainty that appellant's back symptoms/injury were not related in any fashion to her rheumatoid arthritis. He maintained that her surgery was performed for a herniated disc and was not related to her rheumatoid arthritis.

OWCP received a December 16, 2016 report from Dr. Lee who again reiterated his prior lumbar diagnoses.

By decision dated March 1, 2017, OWCP denied modification of the September 3, 2015 decision. It found that the medical evidence submitted did not provide a rationalized medical opinion substantiating that appellant's additional medical conditions and continuing disability were causally related to the accepted December 18, 2004 employment injury.

LEGAL PRECEDENT -- ISSUE 1

Once OWCP accepts a claim, it has the burden of justifying termination or modification of compensation. After it has been determined that an employee has disability causally related to his or her employment, OWCP may not terminate compensation without establishing that the disability had ceased or that it was no longer related to the employment.[2] Its burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[3]

[2] *Jason C. Armstrong*, 40 ECAB 907 (1989).

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

The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability.[4] To terminate authorization for medical treatment, OWCP must establish that appellant no longer has residuals of an employment-related condition, which would require further medical treatment.[5]

Section 8123(a) of FECA provides in pertinent part: if there is 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 an examination.[6] Where a case is referred to an impartial medical examiner 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.[7]

ANALYSIS -- ISSUE 1

The Board finds that OWCP did not meet its burden of proof to justify termination of appellant's wage-loss compensation and medical benefits due to an unresolved conflict in the medical opinion evidence.

OWCP accepted that appellant sustained an L5-6 herniated disc due to the accepted December 18, 2004 employment injury. By decision dated December 23, 2014, it terminated appellant's wage-loss compensation and medical benefits effective that day based on the opinion of Dr. Askin, a second opinion physician. This decision was affirmed by an OWCP hearing representative in a September 3, 2015 decision. In a March 1, 2017 decision, OWCP denied appellant's request for modification.

The Board finds that there is an unresolved conflict in the medical evidence between the opinions of appellant's treating physician, Dr. Lee, and the second opinion physician, Dr. Askin.

Dr. Lee began treating appellant on November 24, 2014. On that date, he reported findings on physical examination and reviewed diagnostic test results. Dr. Lee assessed annular tear at L5-S1, disc herniation at L5-S1, clinical lumbar radiculopathy, muscle spasm, and chronic pain syndrome due to trauma. He opined that these conditions developed after appellant's December 18, 2004 accepted work-related injury. Dr. Lee determined that she had not reached MMI. He concluded that appellant was permanently and totally disabled.

In an October 17, 2014 report, the second opinion physician, Dr. Askin, opined that appellant had no residuals or disability due to her accepted L5-6 herniated disc. He acknowledged that, while appellant may have experienced pain associated with the accepted injury, it was a temporary expression of discomfort. Dr. Askin maintained that lingering complaints of pain so many years later could not have been on the basis of the accepted injury. He noted that the accepted

[4] *T.P.*, 58 ECAB 524 (2007); *Kathryn E. Demarsh*, 56 ECAB 677 (2005).

[5] *Kathryn E. Demarsh, id.; James F. Weikel*, 54 ECAB 660 (2003).

[6] 5 U.S.C. § 8123(a); *R.C.*, 58 ECAB 238 (2006); *Darlene R. Kennedy*, 57 ECAB 414 (2006).

[7] *V.G.*, 59 ECAB 635 (2008); *Sharyn D. Bannick*, 54 ECAB 537 (2003); *Gary R. Sieber*, 46 ECAB 215 (1994).

condition was of historical utility only based on the SOAF. Dr. Askin attributed appellant's current back pain to nonwork-related degenerative disc disease and/or rheumatoid arthritis. He explained that she was at an age when run-of-the-mill degenerative disc disease was frequently the best explanation for back pain. Dr. Askin further explained that there was no clinical finding to support continuing residuals of the accepted employment injury. He determined that appellant had reached MMI with regard to the accepted condition. Dr. Askin concluded that she was capable of returning to her usual job without restrictions. In addition, he concluded that further medical treatment of the accepted condition was not indicated.

Appellant submitted a series of reports from treating physicians following Dr. Askin's second opinion report supporting continuing employment-related residuals and disability. In a November 26, 2014 report, Dr. Abrams examined appellant and provided a clinical impression of lumbar radiculopathy. He opined that the diagnosed condition was directly related to the accepted December 18, 2004 work injury.

In his December 3, 2014 report, Dr. Lee disagreed with Dr. Askin's conclusion that appellant no longer had any residuals or disability due to the accepted December 18, 2004 work injury. He explained that a January 11, 2005 lumbar MRI scan did not show degenerative changes, rather it revealed L4-5 disc bulge, L5-S1 disc herniation, annular tear, and effacing thecal sac. Dr. Lee indicated that Dr. Askin did not refer to any medical records to support that appellant's L5-S1 disc herniation and annual tear were degenerative disorders. The Board notes that appellant has the burden to establish any additional conditions for which compensation is claimed are causally related to the accepted employment injury.[8] Dr. Lee relative to how bending to pick up mail out of containers on December 18, 2004 caused appellant's annular tear, as well as her chronic pain syndrome, which were not accepted conditions. He also opined that appellant's underlying dormant rheumatoid arthritis was aggravated by the accepted employment injury. Dr. Lee determined that she had not reached MMI. He concluded that the work-related injury caused a permanent loss of a function of the body. Dr. Lee completed a Form OWCP-5c on October 3, 2014 which indicated that appellant was totally and permanently disabled due to her L5-S1 annular tear, severe low back pain, and bilateral lower extremity weakness.

Accordingly, at the time OWCP terminated appellant's compensation on December 23, 2014, there remained an unresolved conflict in the medical opinion evidence as to whether appellant had residuals and disability from the accepted employment injuries.[9] Dr. Askin concluded that appellant had no residuals or disability and that the accepted condition had resolved. Dr. Lee's reports discussed appellant's continuing symptomatology and opined that appellant continued to have residuals and disability from the accepted condition.

It is well established that where there exist opposing medical reports of virtually equal weight and rationale, the case should be referred to an impartial medical specialist for the purpose of resolving the conflict.[10] OWCP should have properly resolved the conflict prior to termination

[8] *See C.L.*, Docket No. 17-0949 (issued September 19, 2017).

[9] *See J.S.*, Docket No. 15-0872 (issued September 28, 2016).

[10] *Supra* note 6.

of compensation.[11] As OWCP failed to resolve the conflicting medical opinion evidence, the Board finds that it did not meet its burden of proof to terminate benefits.[12]

CONCLUSION

The Board finds that OWCP did not meet its burden of proof to terminate appellant's wage-loss compensation and medical benefits on December 23, 2014. In light of the Board's disposition on the first issue, the second issue is moot.

ORDER

IT IS HEREBY ORDERED THAT the March 1, 2017 decision of the Office of Workers' Compensation Programs is reversed.

Issued: May 10, 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

[11] *R.R.*, Docket No. 15-0380 (issued April 10, 2015); *S.J.*, Docket No. 14-1821 (issued January 23, 2015).

[12] *See J.S.*, Docket No. 15-0872 (issued September 28, 2016); *V.Y.*, Docket No. 14-0828 (issued November 14, 2014).