# United States Department of Labor
# Employees' Compensation Appeals Board

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| **A.C., Appellant** | ) | |
| **and** | ) | **Docket No. 10-1521** |
| | ) | **Issued: April 13, 2011** |
| **U.S. POSTAL SERVICE, POST OFFICE, Dallas TX, Employer** | ) | |

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

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

### ***JURISDICTION***

On May 17, 2010 appellant filed a timely appeal from a February 8, 2010 merit decision of the Office of Workers' Compensation Programs denying her claim for wage-loss compensation and terminating her right to medical benefits. Pursuant to the Federal Employees' Compensation Act[1] 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 appellant is entitled to wage-loss compensation commencing September 26, 2008 causally related to her accepted employment injury; and (2) whether the Office properly terminated appellant's right to medical benefits.

[1] 5 U.S.C. § 8101 *et seq.*

## ***FACTUAL HISTORY***

On February 5, 2008 appellant, a 29-year-old mail processing clerk, filed an occupational disease claim alleging that she sustained an injury to her chest wall due to pulling heavy buckets at work. The Office accepted her claim for costochondritis (unspecified bone and cartilage disorder) and placed her on the periodic rolls.[2]

Appellant was treated by Dr. Jill Waggoner, Board-certified in family medicine. On August 4, 2008 Dr. Waggoner released appellant to modified duty, four hours per day, three days a week. On September 8, 2008 she opined that appellant was able to work seven and one-half hours per day, four days per week, provided that she comply with certain restrictions, which included: lifting no more than 10 pounds, 2 hours per day; standing and walking no more than 3 hours per day; pulling and pushing a maximum of 2 hours per day; and simple grasping, fine manipulation, reaching above the shoulder and driving a maximum of 4 hours per day. Appellant was precluded from climbing, kneeling, bending, stooping or twisting. She returned to work on September 24, 2008.

On October 10, 2008 appellant filed a Form CA-7 claiming total disability from work commencing September 26, 2008. In an October 24, 2008 letter, the Office informed her that it considered her claim a notice of recurrence of disability. Appellant was asked to explain whether she stopped working in her light-duty job due to an alleged change in the light-duty assignment such that it no longer met the restrictions set by her physician or to provide a narrative report from her physician in support of a worsening of her employment-related condition, such that she could no longer perform the duties of the position.

The Office referred appellant to Dr. James Hood, a Board-certified orthopedic surgeon, for a second opinion examination and an opinion regarding her ability to perform the duties of her mail processor position. In an October 27, 2008 report, Dr. Hood found that she had no work limitations due to the accepted costochondritis condition. He stated, however, that nonwork-related conditions, including hypertension and asthma, required certain restrictions. Dr. Hood noted that coughing associated with her asthma aggravated the costochondritis.

In a November 10, 2008 report, Dr. Waggoner noted that she increased appellant's scheduled work hours to 7.5 hours, four days a week to get her back into a routine and to allow her body an adjustment period; however, her symptoms worsened. Appellant reported stabbing pain in her chest wall, difficulty breathing and difficulty accomplishing daily activities. She reported relief with minimizing movement, very slow breathing and bed rest. Dr. Waggoner stated that the repetitive nature of appellant's light-duty job, which required constant standing, throwing mail into buckets and then filling metal containers with buckets over 5 to 10 pounds, was a contributing factor to the chronic costochondritis. Appellant's workplace stress on the muscles of the chest wall and exacerbated pain in the chest area. She noted that while chronic costochondritis can last for several months or years, it can reappear at different intervals

[2] This case was previously before the Board. In a September 9, 2009 decision, the Board set aside the Office's September 29, 2008 overpayment decision and remanded the case for further development. (Docket No. 09-177, issued September 9, 2009).

throughout the illness. Dr. Waggoner found that appellant was unable to perform work-related duties of any kind.

The Office found a conflict in medical opinion between Dr. Waggoner and Dr. Hood as to appellant's work capabilities. It referred her to Dr. Bernie L. McCaskill, a Board-certified orthopedic surgeon, in order to resolve the conflict. The Office asked Dr. McCaskill to provide an opinion concerning whether the costochondritis was a result of the accepted employment injury; to discuss the nature of the underlying conditions, their natural or traditional course, how the underlying conditions may have been affected by appellant's employment as determined by medical records and whether such affects, if any, caused material changes in the underlying conditions. It also asked him to address whether any aggravation of the claimant's underlying conditions caused by factors of her employment caused disability beginning September 26, 2008. The Office provided Dr. McCaskill with a May 16, 2008 statement of accepted facts (SOAF) which described the history of appellant's injury and treatment, as well as her employment duties and the physical requirements of her light-duty job. The SOAF reflected that her claim was accepted for costochondritis.

In a report dated December 23, 2008, Dr. McCaskill reviewed a history of injury and treatment. He noted that the Office had not specified appellant's accepted injuries. On examination, appellant demonstrated a full active range of motion of the cervical spine other than for mild limitation of active right cervical rotation and active elevation of each shoulder only to 90 degrees. She demonstrated a full active range of motion of the shoulders, elbows, wrists and hands bilaterally. Appellant was somewhat diffusely tender along the right side of her sternum. There were no abnormal neurological findings noted in either upper extremity. Strength in all motor groups in both upper extremities was normal. Triceps, biceps and brachioradialis reflexes were symmetrical on the left and right. There was no evidence of peripheral nerve entrapment in either upper extremity.

Dr. McCaskill stated that the diagnosis of costochondritis was based upon subjective complaints only. In his experience, it was unusual for costochondritis to be so severe and persistent and that its symptoms generally resolved within six to twelve weeks of their onset, particularly if it was the result of repetitive activity as opposed to a specific traumatic event or underlying medical condition. Dr. McCaskill found no evidence of any underlying conditions that might affect appellant's current complaints and no credible objective evidence of injury. Because there was no history given of previous similar problems or an underlying medical causation, he was unable to state that her subjective complaints were an aggravation of some preexisting problem. Dr. McCaskill prescribed a bone scan and computerized tomography (CT) scan of appellant's chest in order to confirm the presence of active inflammation.

In a final report dated October 14, 2009, Dr. McCaskill stated that no abnormalities were described on an October 12, 2009 report of a chest CT scan.[3] He opined that, in light of her unremarkable chest CT scan, it was "most unlikely that a bone scan would demonstrate any significant abnormalities" and that "if in fact the bone scan [did] demonstrate significant

[3] The Board notes that a CT scan of the chest was deferred until October 12, 2009 upon the advice of Dr. Waggoner, due to appellant's pregnancy. Appellant did not undergo a bone scan.

abnormalities, then [his] reply to [the Office's] specific questions may change." Dr. McCaskill stated:

> "I see no credible objective evidence of a significant ongoing musculoskeletal injury of any type and no explanation for the relatively severe and persistent nature of [appellant's] complaints. I am, however, unable to state that it is not impossible that she has some level of symptoms related to costochondritis and that that may be related to activity at work."

On December 11, 2009 Dr. Waggoner opined that appellant was indefinitely totally disabled.

In a February 8, 2010 decision, the Office denied appellant's compensation claim, finding that the medical evidence failed to establish that she was disabled from work during the claimed period due to her accepted injury. It also terminated her entitlement to medical treatment.

## ***LEGAL PRECEDENT -- ISSUE 1***

When an employee who is disabled from the job she held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence of record establishes that she can perform the light-duty position, the employee has the burden of establishing by the weight of the reliable, probative and substantial evidence, a recurrence of total disability and of showing that she cannot perform such light duty. As part of this burden, the employee must show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the light-duty job requirements.[4]

The Board notes that the term disability, as used in the Act, means incapacity, because of an employment injury, to earn the wages that the employee was receiving at the time of injury.[5] Whether a particular injury caused an employee disability for employment is a medical issue which must be resolved by competent medical evidence.[6] When the medical evidence establishes that the residuals of an employment injury are such that, from a medical standpoint, they prevent the employee from continuing in the employment held when injured, the employee is entitled to compensation for any loss of wage-earning capacity resulting from such incapacity.[7] Recurrence of disability means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition which had resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness.[8]

[4] *Terry R. Hedman*, 38 ECAB 222 (1986).

[5] *Patricia A. Keller*, 45 ECAB 278 (1993).

[6] *Debra A. Kirk-Littleton*, 41 ECAB 703 (1990).

[7] *Clement Jay After Buffalo*, 45 ECAB 707 (1994).

[8] 20 C.F.R. § 10.5(x); *see S.F.*, 59 ECAB 525 (2008).

Section 8123(a) of the Act provides in pertinent part that 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.[9] This is called a referee examination and the Office will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[10] In situations where there exist 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.[11]

## ***ANALYSIS -- ISSUE 1***

The Board finds that this case is not in posture for decision on the issue of whether appellant is entitled to wage-loss compensation during the claimed period, as there remains an unresolved conflict in medical opinion.

Appellant returned to her light-duty position in accordance with her physician's restrictions. After her return to work, Dr. Waggoner opined that she was disabled from performing the activities associated with her light-duty job as of September 26, 2008 due to her accepted condition. The Office's second opinion physician, Dr. Hood, found that appellant had no limitations due to the accepted costochondritis condition. The Office properly referred appellant to Dr. McCaskill for an impartial medical examination in order to resolve the conflict between Dr. Hood and Dr. Waggoner. The Board finds that Dr. McCaskill's opinion is insufficiently rationalized to resolve the conflict in medical opinion. Therefore, the case will be remanded for further development.

In the initial December 23, 2008 report, Dr. McCaskill provided a history of injury and treatment and examination findings. He did not, however, provide an accurate factual background or a definitive and rationalized opinion as to whether appellant was disabled during the claimed period due to her accepted condition. Dr. McCaskill's statement that the Office had not specified appellant's accepted injuries, reflects that he did not consider the Office's statement of accepted facts, which clearly listed the acceptance of costochondritis. He noted that in his experience it was unusual for costochondritis to be so severe and persistent and that its symptoms generally resolve within 6 to 12 weeks of their onset, particularly if it is the result of repetitive activity as opposed to a specific traumatic event or underlying medical condition. Noting the absence of objective evidence of injury, Dr. McCaskill prescribed bone and CT scans of appellant's chest in order to confirm the presence of any active inflammation. The record reflects that a chest CT scan was obtained on October 12, 2009.[12]

[9] 5 U.S.C. § 8123(a).

[10] *R.H.*, 59 ECAB 382 (2008); 20 C.F.R. § 10.321.

[11] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

[12] Diagnostic testing was delayed due to appellant's pregnancy.

Dr. McCaskill's October 14, 2009 report advised that the CT scan of the chest was unremarkable. He stated that it was "most unlikely that a bone scan would demonstrate any significant abnormalities." Dr. McCaskill saw no credible objective evidence of a significant ongoing musculoskeletal injury of any type and no explanation for the relatively severe and persistent nature of appellant's complaints. But he was "unable to state that it is not impossible that she has some level of symptoms related to costochondritis and that that may be related to activity at work." Dr. McCaskill's opinion is speculative and not fully rationalized. Although he obtained a chest CT scan that did not show evidence of inflammation, he did not rule out the diagnosis of costochondritis or that appellant's symptoms were belated to her actives at work. Moreover, Dr. McCaskill did not address the period of disability at issue. For these reasons, the Board finds his opinion to be of limited probative value and insufficient to resolve the conflict between Dr. Hood and Dr. Waggoner.

Proceedings under the Act are not adversarial in nature and the Office is not a disinterested arbiter.[13] While appellant has the responsibility to establish entitlement to compensation, the Office shares responsibility in the development of the evidence. It has the obligation to see that justice is done.[14] Accordingly, once the Office undertakes to develop the medical evidence further, it has the responsibility to do so in the proper manner.[15] As it undertook development of the medical evidence by referring appellant to Dr. McCaskill, it had an obligation to secure an opinion adequately addressing the relevant issues.[16] Therefore, the case will be remanded to the Office for a supplemental report from him. If Dr. McCaskill is unwilling or unable to clarify or elaborate on his opinion, the case should be referred to another appropriate specialist. After such further development as the Office deems necessary, an appropriate decision should be issued regarding this matter.

## ***LEGAL PRECEDENT -- ISSUE 2***

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation.[17] After it has been determined that an employee has disability causally related to her employment, the Office may not terminate compensation without establishing that the disability had ceased or that it was no longer related to the employment.[18] The Office's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[19]

[13] *Vanessa Young*, 55 ECAB 575 (2004).

[14] *Richard E. Simpson*, 55 ECAB 490 (2004).

[15] *Melvin James*, 55 ECAB 406 (2004).

[16] *Peter C. Belkind*, 56 ECAB 580 (2005).

[17] *A.W.*, 59 ECAB 593 (2008).

[18] *J.M.*, 58 ECAB 478 (2007).

[19] *See Del K. Rykert*, 40 ECAB 284 (1988).

The right to medical benefits for an accepted condition is not limited to the period of entitlement to compensation for disability.[20] To terminate authorization for medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition, which requires further medical treatment.[21]

The Office's procedures state that a notice of proposed termination of medical benefits must be provided before terminating: an authorization for treatment, the services of a specific physician, a specific service or all medical treatment.[22] The procedures also state that notice of proposed termination of medical benefits is not required when the physician indicates that further medical treatment is not necessary or that treatment has ended or the Office denies payment for a particular charge on an exception basis.[23]

## ***ANALYSIS -- ISSUE 2***

In its February 8, 2010 decision, the Office terminated appellant's entitlement to medical benefits. The Board finds that the Office improperly terminated her right to medical benefits for her accepted costochondritis.

Under the Office's procedures, in order to terminate appellant's medical benefits, a notice of proposed termination should have been sent to appellant allowing her 30 days to respond. Since there is no evidence that the Office provided notice or an opportunity to respond prior to termination of all her medical benefits, the termination was improper in this case.[24] Moreover, the opinion of Dr. McCaskill as noted did not rule out appellant's work activities as a cause of her symptoms or disability. Accordingly, the February 8, 2010 decision will be reversed as to the termination of appellant's medical benefits.[25]

## ***CONCLUSION***

The Board finds that this case is not in posture for decision as to whether appellant is entitled to compensation for total disability subsequent to September 26, 2008. The Board further finds that the Office improperly terminated her entitlement to medical benefits.

[20] *T.P.*, 58 ECAB 524 (2007).

[21] *I.J.*, 59 ECAB 408 (2008); *Kathryn E. Demarsh*, 56 ECAB 677 (2005).

[22] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Disallowances*, Chapter 2.1400.6(b) (March 1997).

[23] *See id.* at Chapter 2.1400.6(d).

[24] *Supra* note 21.

[25] The Board notes that the issue before the Office was whether appellant was entitled to compensation for total disability during the claimed period, rather than whether her accepted condition had resolved.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the Office of Workers' Compensation Programs' February 8, 2010 decision is reversed as to the termination of appellant's medical benefits. The February 8, 2010 decision is set aside and remanded for action consistent with this decision on the issue of her entitlement to wage-loss compensation subsequent to September 26, 2008.

Issued: April 13, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board