United States Department of Labor
Employees' Compensation Appeals Board

J.T., Appellant	)	
and	)	**Docket No. 13-681**
	)	**Issued: July 19, 2013**
DEPARTMENT OF THE ARMY, MCALESTER ARMY AMMUNITION PLANT, McAlester, OK, Employer	)	

Appearances:
Debra Hauser, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On January 25, 2013 appellant,through his attorney, filed a timely appeal from an August 1, 2012merit 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.

ISSUE

The issue is whether OWCP met its burden of proof to terminate appellant's wage-loss compensation benefits effective July 29, 2012 on the grounds that he no longer had any residuals or disability causally related to his accepted back injuries.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On June 15, 2011 appellant, then a 41-year-old explosives operator, filed a traumatic injury claim alleging that on June 9, 2011 he experienced pain in his legs and upper back and numbness in his arms and fingers as a result of lifting trays and boxes on a pellet crew. He stopped work and returned on June 13, 2011. OWCP accepted appellant's claim for back sprain, thoracic and lumbar region. Appellant stopped work again on August 1, 2011 and received disability compensation.

On January 17, 2012 OWCP referred appellant, together with a statement of accepted facts and the medical record, to Dr. Dennis Foster, a Board-certified orthopedic surgeon, for a second-opinion examination to determine the extent of his continuing employment-related residuals and disability. In a February 6, 2012 report, Dr. Foster reviewed an accurate history of injury,medical treatment and light-duty restrictions. He related appellant's complaints of mid and low back pain and numbness and tingling affecting both hands. Dr. Foster stated that appellant had problems with his back in the past when he was thrown from a horse and suffered a low back fracture in 2005. He underwent numerous surgeries and was on and off work until the June 9, 2011 employment injury.

Upon examination, Dr. Foster observed no pain of the head and neck region upon deep palpation or about the posterior aspect of the cervical spine. Range of motion of the cervical spine was extension to 50 degrees, forward flexion to 35 degrees and rotation to either side to 80 degrees. Examination of the mid and low back revealed complaints of pain, but no spasm, upon deep palpation through the mid-back between the shoulder blades. Dr. Foster reported that flexibility of the thoracolumbar spine demonstrated fairly rigid bend forward to about 50 degrees and extension was slightly beyond neutral. Straight leg raise testing was negative bilaterally. Deep tendon reflexes were one plus and symmetric at both knees and two plus and symmetric at both ankles. Dr. Foster reviewed the September 20, 2011 magnetic resonance imaging (MRI)scansof the cervical and lumbar spine and noted mild-to-moderate disc protrusion at C4-5 and C5-6 and mild degenerative change at those two levels. The MRI scan of the lumbar spine showed evidence of a previous L5-S1 fusion. A November 11, 2011 MRI scan of the cervical spine revealed multiple small disc bulges, most notably at T5-6, T6-7, T7-8, T9-10 and T11-12.

Dr. Foster stated that appellant had ongoing complaints of his neck, thoracic and lumbar spine but he found nothing dramatic in the neck or back, from an objective standpoint, that would be disabling or necessarily related to the June 9, 2011 employment injury. He opined that appellant exaggerated his symptomatology and that his disabling condition was subjective in nature. Based on appellant's ongoing complaints, he would not be capable of returning to any type of work but stated that it was difficult to know if his complaints were real or purely subjective. Dr. Foster reported that it was unlikely that any treatment would improvethe complaints. In a work capacity evaluation form,henoted that appellant was not capable of performing his usual job or working for eight hours with restrictions.

In a January 17, 2012 report, Dr. Stewart C. Smith, a Board-certified neurological surgeon,noted appellant's complaints of pain in his neck, lower back, mid-back and some left and right leg pain. He related that last June 2011appellant worked at the employing establishment and felt pain across his shoulder and upper thoracic area when he lifted some very

heavy pallets. Dr. Smith reviewed appellant's history and reported a previous history of an L5-S1 fusion with instrumentation removal in 2009. Examination revealed back pain and calf muscle cramps. No leg pain or localized joint pain was noted. Dr. Smith noted that a cervical MRI scan revealed a collapsing of the disc at C4-5 and C5-6 and some unconvertebral joint spurring causing some bilaterally foraminal stenosis. X-ray of the thoracic spine demonstrated two small disc herniations but no cord compression. Dr. Smith stated that the lumbar showed a previous fusion across the L5-S1 level. He diagnosed lumbago, herniated discs and cervical spondylosis.

In a January 17, 2012 work capacity evaluation form, Dr. John W. Ellis, Board-certified in family medicine, stated that appellant's accepted conditions were deranged discs, sprain of thoracic and lumbar spine, deranged discs in the back, L5-S1 nerve root impairment and reflex spasm into cervical. He indicated that appellant was not capable of performing his usual job and was totally disabled for an indefinite period. Dr. Ellis recommended furthering testing and evaluation.

In a January 24, 2012 report, Dr. Gregory A. Rogers, an occupational medicine specialist, stated that he examined appellant on June 13, 2011 for complaints of back pain. He noted that appellant had previous back problems leading to a spinal fusion in the lumbar area and related that appellant attributed the cause of his inability to perform any duties to a new disc problem he had in his thoracic spine. Upon examination, Dr. Rogers observed no significant point tenderness consistent to any dermatome. He noted that appellant did not demonstrate the appropriate pattern of pain with movement because his symptoms and reports kept changing during the examination. While he was certain appellant had spinal problems, Dr. Rogers was uncertain as to any findings suggestive of a disease process so severe he could not have performed some form of light duty. He explained that he was puzzled by the case and noted that although appellant was reportedly so incapacitated by a severe spinal problem that he could not perform the lightest of duties, there was no objective evidence of this condition.

In a February 13, 2012 report, Dr. Ellis stated that appellant continued to have significant decreased range of motion of the cervical and lumbar areas and numbness and tingling down both legs and into his feet. He noted that the effects of the work injury had not ceased and that appellant's condition had worsened. Dr. Ellis reported that appellant was not able to return to any type of employment and recommended continued medical treatment. He included a workcapacity evaluation form indicating that appellant was totally disabled for an indefinite period of time.

On February 13, 2012 appellant underwent cervical discogram surgery.

In a February 16, 2012 report, Dr. Howard R. Jarrell, Board-certified in neurology and psychiatry,noted appellant's complaints of mid and lower back pain and numbness and tingling in both hands and arms. He reported appellant's history for lower back trauma resulting in L5-S1 interbody fusion and subsequent removal of instrumentation. Dr. Jarrell noted that a 2011 MRI scan of the thoracic spine revealed small disc protrusions at multiple levels, most notably T5-6 and T6-7. A lumbar MRI scan demonstrated interbody and posterior mechanical fusion at L5-S1. Dr. Jarrell related that appellant had three lumbar operations including L5-S1 interbody fusion and reattachment of traumatic amputation. He diagnosed chronic thoracic syndrome,

chronic lumbar radicular syndrome, left greater than right, thoracic disc protrusions and history of L5-S1 interbody fusion.

In a March 6, 2012 report, Dr. Smith noted that appellant had undergone a cervical discogram since his last visit. He continued to complain of axial neck and arm pain. An MRI scanof appellant's lumbar spine revealed what appeared to be recurrent disc osteophyte complex or possible scar tissue. Upon examination, Dr. Smith observed discomfort with range of motion of appellant's neck and a little bit of muscular tenderness to palpation along the upper shoulder girdle and trapezium area. Examination of the lower extremities revealed dysesthesia down in a perfect L5 distribution, lateral shin, top of his foot, big toe with some irritability with straight leg raising. Dr. Smith requested that appellant's accepted diagnoses be upgraded to cervical radiculopathy, lumbar radiculopathy and cervical degenerative disc disease.

In a March 13, 2012 report, Dr. Ellis disagreed with Dr. Foster's second-opinion report and stated that appellant was recommended to undergo another cervical spine surgery. Even though Dr. Foster stated that appellant was exaggerating his symptoms, he noted that appellant could not return to any type of work at this time. Dr. Ellis reported that appellant continued to have significant decreased range of motion of the cervical and lumbar areas and muscle spasms and tightness during the examination. He explained that any type of extended standing, walking or even sitting would increase the symptoms. Dr. Ellis opined that appellant would remain temporarily totally disabled until further treatment.

OWCP determined that a conflict in medical opinion arose between Dr. Fosterand Dr. Ellis whether as to appellant had any continuing residuals or disability due to his accepted employment injuries. On April 2, 2012 it referred appellant, together with a statement of accepted facts and the medical record, to Dr. Sami Framjee, a Board-certified orthopedic surgeon, for an impartial medical examination.

In a May 2, 2012 report, Dr. Framjee provided an accurate history of injury and related appellant's complaints of neck and back pain, tingling in his fingers, headaches and tightness in his shoulders. He reviewed the medical history and noted that appellant fractured his lumbar spine when he was thrown off a horse. Appellant underwent lumbar fusion surgery twice and had the screws removed in 2007. Dr. Framjee noted that a September 20, 2011 MRI scan of appellant's cervical spine revealed moderate left neural foraminal stenosis at C5-6, mild posterior bulge, mild bilateral neural foraminal narrowing at C4-6 and mild-to-moderate bilateral facet arthrosis. A September 20, 2011 MRI scan of the lumbar spine revealed postoperative changes from interbody and prior posterior mechanical fusion, mild left neural foraminal narrowing and moderate bilateral neural foraminal stenosis at L4-5 from facet hypertrophy and diffuse bulge.

Upon examination, Dr. Framjee observed no point tenderness on palpation of the paracervical muscle mass or supraspinatus mass, no trigger points or reflex muscle spasms and no neurological deficits in the right or left upper extremity. Motor power was 4+ bilaterally. Dr. Framjee noted that appellant resented undergoing range-of-motion testing of the cervical spine. Examination of the thoracolumbar spine revealed no acute tenderness on palpation and some discomfort on palpation. Range of motion of the thoracolumbar spine was forward flexion to 40 degrees, extension to 20 degrees, right and left flexion to 30 degrees and right and left

rotation to 20 degrees. Straight leg raise testing was negative bilaterally. Dr. Framjee reported that sensory x-rays of the cervical spine demonstrated diffuse cervical spondylosis, primarily at C4-5, C5-6 and C6-7 but no fractures. X-rays of the thoracic spine revealed no fractures and minimal degenerative changes. X-rays of the lumbar spine showed residuals of a laminectomy defect at the L5-S1 level, interbody fusion and L5-S1 postlateral transverse process fusion. Dr. Framjee opined that appellant did not have any medically identifiable injury to the cervical, lumbar or thoracic spine related to the June 9, 2011 work incident. He reported that appellant could return to modified duty as a machine operator with restrictions of no lifting more than 25 pounds.[2] In a work capacity evaluation form, Dr. Framjee found that appellant was able to work eight hours a day with restrictions of no lifting over 25 pounds.

In a May 10, 2012 report, Dr. Jarrell related appellant's complaints of mid and lower back pain radiating into the rumps and posterior thigh. He noted a history or lower back trauma resulting in L5-S1 interbody fusion and subsequent removal of instrumentation. Dr. Jarrell diagnosed chronic thoracic syndrome and lumbar radicular syndrome.

In a May 23, 2012 report, Dr. Smith disagreed with Dr. Foster's evaluation of appellant. He stated that appellant was a candidate to undergo cervical fusion at the C4-5 and C5-6 levels that could provide a significant relief of his neck pain.

On May 24, 2012 OWCP issued a notice of proposed termination of appellant's wage-loss compensation and medical benefits based on Dr. Framjee's May 2, 2012 referee medical report. Appellant was advised that he had 30 days to submit additional relevant evidence or argument if he disagreed with the proposed action.

In May 24 and July 19, 2012 work capacity evaluation forms, Dr. Ellis noted diagnoses of deranged discs, lumbar and thoracic sprain and L5-S1 spinal nerve post management. He checked a box marked "no" that appellant was not able to perform his usual job or work eight hours a day with restrictions.

In a May 29, 2012 letter, appellant's counsel related that appellant was injured on June 9 and 16, 2011 and diagnosed with muscle tendon unit strain of the thoracic and lumbar spine, deranged discs in the back, bilateral L5 and S1 spinal nerve root impairment and bilateral lumbosacral and sciatic nerve impairment. He contended that three physicians, Drs. Smith, Foster, and Ellis, believed that appellant was not able to return to work and there was no need to send him for a referee opinion.

In a June 14, 2012 work capacity evaluation, Dr. Smith noted that appellant was temporarily totally disabled.

In a decision dated August 1, 2012, OWCP terminated appellant's compensation benefits effective July 29, 2012. It found that Dr. Framjee's May 2, 2012 referee report represented the weight of the medical evidence and established that his accepted conditions had ceased and that he no longer had any residuals or disability causally related to his accepted employment injuries.

[2] Dr. Framjee also noted that appellant was not able to return to heavy manual labor as a result of his previous low back surgeries and not the June 9, 2011 work-related injury.

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 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 June 9, 2011 appellant sustained lumbar and thoracic sprains in the performance of duty, while lifting trays and boxes. He was on and off work but had not returned since August 1, 2011. Appellant received disability compensation. The record also reveals that in 2005 hesustained a low back fracture when he was thrown from a horse and underwent numerous back surgeries. In a decision dated August 1, 2012, OWCP terminated appellant's compensation benefits based on the report of the impartial medical examiner, Dr. Framjee. The Board finds that OWCP properly terminated his compensation benefits

[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).

[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).

effective July 29, 2012 on the grounds that he no longer had any residuals or disability causally related to his accepted employment-related conditions.

OWCP found that a conflict in medical opinion arose between appellant's treating physicians, including Drs. Ellis and Jarrell, he and Dr. Foster, an OWCP referral physician. It referred appellant to Dr. Framjee to resolve the conflict. In a May 2, 2012 report, Dr. Framjee provided an accurate history of the June 9, 2011 employment injury and reviewed appellant's medical records. He noted that appellant sustained a previous back injury when he was thrown from a horse and underwent numerous back surgeries. Dr. Framjee noted that an MRI scan of the lumbar spine revealed postoperative changes from interbody and prior posterior mechanical fusion, mild foraminal narrowing and moderate bilateral neural foraminal stenosis at L4-5 from facet hypertrophy and diffuse bulge. Upon examination, he observed no point tenderness on palpation of the paracervical muscle mass or supraspinatus mass, no trigger points or reflex muscle spasms and no neurological deficits in the right or left upper extremity. Examination of the thoracolumbar spine revealed no acute tenderness on palpation and some discomfort on palpation. Straight leg raise testing was negative bilaterally. Dr. Framjee opined that there was no objective evidence that appellant continued to suffer from an injury to the cervical, lumbar or thoracic spine as a result of the June 9, 2011 employment injury. He concluded that appellant could return to modified duty with restrictions of no lifting over 25 pounds.

The Board finds that Dr. Framjee's May 2, 2012 referee medical report is sufficiently detailed and well reasoned to constitute the weight of the medical opinion evidence. Where 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.[11] Dr. Framjee reviewed appellant's history and accurately described the June 9, 2011 employment injury. He conducted an examination and found that the objective evidence did not establish that appellant continued to suffer residuals or disability from his work-related injury. Dr. Framjee explained that appellant did not have any medically identifiable injury to the cervical, lumbar or thoracic spine related to the June 9, 2011 work incident. He did, however, identify postoperative changes related to the surgical procedures appellant underwent for his previous injury, when he was thrown from a horse. The Board finds that Dr. Framjee's opinion represents the special weight of medical opinion evidence and is sufficient to justify OWCP's termination of wage-loss and compensation benefits for the accepted conditions.

The Board finds that the medical evidence submitted after Dr. Framjee's independent medical evaluation report was insufficient to overcome the weight of this report or to create another conflict in medical evidence. Appellant submitted various reports by Drs. Jarrell and Ellis noting diagnosis of deranged discs, lumbar and thoracic sprain and L5-S1 spinal nerve post management. Because these physicians were on one side of the conflict which Dr. Framjee resolved the additional reports are insufficient to overcome the weight accorded Dr. Framjee's report as the impartial medical examiner or to create a new conflict.[12]

[11] *Supra* note 10.

[12] *Dorothy Sidwell,* 41 ECAB 857 (1990).

Appellant also submitted reports by Dr. Smith, who noted that appellant was totally disabled and reported that he was a candidate for cervical fusion at the C4-5 and C5-6 levels. The Board finds, however, that Dr. Smith's report is of limited probative value as he offers no opinion on the cause of appellant's disability or cervical condition nor does he relate his back condition to the June 9, 2011 work-related injury.[13] Thus, his opinion is insufficient to overcome the special weight accorded to Dr. Framjee's impartial medical examination report. The Board finds that Dr. Framjee's opinion continues to constitute the special weight of medical opinion and supports OWCP's decision to terminate appellant's wage-loss and compensation benefits. There is no other medical evidence contemporaneous with the termination of appellant's benefits, which supports that he has any continuing residuals or disability related to his accepted work-related injuries.

On appeal, appellant's counsel alleges that OWCP failed to consider the legal arguments and medical evidence in its termination decision.[14] The Board notes, however, that in its August 1, 2012 decision OWCP provided an accurate history of injury and discussed the pertinent evidence of the record. It properly determined that Dr. Framjee's impartial medical report constituted the special weight of medical evidence. Thus, the Board finds that OWCP properly terminated appellant's wage-loss and compensation benefits.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that OWCP met its burden of proof to terminate appellant's compensation and medical benefits effective July 29, 2012.

[13] *R.E.*, Docket No. 10-679 (issued November 16, 2010); *K.W.*, 59 ECAB 271 (2007).

[14] Appellant's counsel also alleged that OWCP should upgrade appellant's condition per his September 7, 2012 request. Because OWCP has not issued a decision regarding the expansion of appellant's claim, the Board does not have jurisdiction over this issue at this time.

ORDER

IT IS HEREBY ORDERED THAT the August 1, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 19, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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