U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of BERNADETTE M. SMITH and OFFICE OF PERSONNEL MANAGEMENT, FEDERAL INVESTIGATIONS DIVISION, Denver, CO

Docket No. 99-926; Submitted on the Record;
Issued December 6, 2000

DECISION and ORDER

Before DAVID S. GERSON, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether the Office of Workers' Compensation Programs met its burden of proof to terminate appellant's compensation benefits effective December 6, 1997.

The Board has duly reviewed the case on appeal and finds that the Office failed to meet its burden of proof to terminate appellant's compensation benefits.

On January 5, 1993 appellant, then a 48-year-old investigator, filed a claim alleging that she developed bilateral tendinitis as a result of her federal employment duties. The Office accepted her claim for bilateral tendinitis of the forearms and subsequently expanded its acceptance to include left carpal tunnel syndrome with ulnar nerve compression, requiring surgical release. Appellant did not stop work, but was placed into a less physically demanding position. Appellant underwent surgical release of her ulnar nerve, authorized by the Office, on March 28, 1994. By letter dated April 11, 1994, the employing establishment informed the Office that it could no longer accommodate appellant and that no limited-duty position would be available to her when she recovered from surgery. Accordingly, the Office entered appellant on the periodic rolls. In a letter dated November 4, 1997, the Office proposed to terminate appellant's compensation benefits. By decision dated December 4, 1997, the Office terminated appellant's compensation benefits effective December 6, 1997. Appellant, through counsel, requested an oral hearing, which was held on July 22, 1998. In a decision dated October 26, 1998, an Office hearing representative affirmed the December 4, 1997 decision terminating benefits.

Once the Office accepts a claim, it has the burden of proving that the disability has ceased or lessened in order to justify termination or modification of compensation benefits.[1] After it has determined that an employee has disability causally related to his or her federal employment, the Office may not terminate compensation without establishing that the disability

[1] *Mohamed Yunis*, 42 ECAB 325, 334 (1991).

has ceased or that it is no longer related to the employment.[2] Furthermore, the right to medical benefits for an accepted condition is not limited to the period of entitlement for disability.[3] To terminate authorization for medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition which require further medical treatment.[4]

Appellant's primary attending physician, Dr. John S. Hughes, Board-certified in occupational medicine, completed several reports in support of appellant's continuing disability. In his initial report dated June 20, 1996, Dr. Hughes noted appellant's history of injury and medical treatment, documented his findings on physical examination, and listed his diagnoses as left ulnar neuritis with sensory and mild motor residual impairment, right extensor myositis with involvement of the lateral epicondyle of the elbow, bilateral wrist synovitis with frank crepitation on the right and with ongoing pain, and slight limitations in ranges of motion on the left, osteoporosis and hypothyroidism. He opined that appellant's left ulnar neuritis, bilateral extensor myositis, right lateral epicondylitis and bilateral wrist synovitis were solely related to appellant's repetitive upper extremity use at work. With respect to appellant's physical capabilities, Dr. Hughes stated that appellant's condition had stabilized around September 1994, 3 months following her surgery, and that she had a 14 percent permanent impairment of her right upper extremity and a 9.4 percent permanent cumulative trauma disorder. He additionally completed a work capacity evaluation form, on which he indicated that appellant could work 8 hours a day, within the restrictions of no typing or overhead reaching or lifting, handwriting no more than 15 minutes per hour and lifting, pushing or pulling no more than 10 pounds on an occasional basis. Dr. Hughes further indicated that these physical limitations were due to appellant's employment-related conditions.

The Office referred appellant for a second opinion evaluation with Dr. Philip Heyman, a Board-certified orthopedic surgeon. In a report dated October 1, 1997, Dr. Heyman reviewed the statement of accepted facts and performed a physical examination. He stated that appellant had diffuse and nonspecific upper extremity complaints and that the only "hard" findings present were well-healed surgical scars. Dr. Heyman concluded that in light of the fact that appellant had subjective symptoms with no substantiating hard findings, he did not believe that appellant had any disabling residuals resulting from any specific injury or from surgery and that there was no objective reason why any restrictions should be ongoing.

[2] *Id.*

[3] *Furman G. Peake*, 41 ECAB 361, 364 (1990).

[4] *Id.*

In a report dated November 17, 1997, Dr. Hughes, appellant's treating physician, noted appellant's history of injury and listed his diagnoses as left carpal tunnel syndrome and left cubital tunnel syndrome, improved post surgery, left forearm and wrist tendinitis with persistence and new development of wrist ganglion cyst, and persistent right forearm and wrist tendinitis. He stated:

> "[Appellant] presents with clinical evidence of residuals that are within a reasonable degree of medical probability related back to her cumulative trauma disorder of November 5, 1992…. Clinical evidence includes objective parameters of pathology. There is definite clinical consistency in wrist tendinitis and today she presents with a small and tender ganglion cyst over the volar aspect of her left wrist at the level of the base of the thumb. This reflects underlying inflammatory pathology that I believe stems from her work-related cumulative trauma disorder. She has symptoms over the right upper extremity and in addition has objective low-grade crepitation over the elbow and wrist joints also indicating some chronic, low-grade inflammation in the upper extremities. All of her clinical findings are consistent with residuals of a cumulative trauma disorder involving both upper extremities. This has been well documented in [appellant's] case and I believe that she has both persistent impairment and disability that stems from her occupational condition."

Appellant also submitted a report dated April 21, 1998 from Dr. David J. Conyers, who noted the presence of scar tissue, bone and possibly a ganglion cyst at the area of the triscaphoid joint and FCR tendon sheath, he stated that on physical examination appellant had lateral epicondyle tenderness, additional tenderness which is centered over the supinator muscle where the radial nerve passes through it's tunnel and some pain radiating down from that area towards the wrist. Dr. Conyers concluded that appellant did have symptoms of lateral epicondylitis and radial tunnel and recommended that she be seen by a physiatrist.

In a report dated June 29, 1998, Dr. Douglas E. Hemler, a Board-certified physiatrist, reviewed appellant's occupational and medical history and after performing a physical examination, diagnosed status post left median neuropathy, carpal tunnel syndrome and ulnar neuropathy at the elbow with partial improvement status post release, persistent bilateral symptoms within an ulnar distribution, superimposed bilateral joint pain involving the radiocarpal joint and the ulnar carpal joint, and superimposed enthesopathy of the elbows involving both the medial and lateral epicondyles. He further recommended a course of treatment. In a follow-up report dated July 27, 1998, Dr. Hemler stated, in pertinent part, that appellant's current condition was directly causally related to her employment and stated that appellant should avoid keyboarding activities or confine this to an as tolerated level and confine handwriting activities to less than 15 minutes hourly and further stated that he did not agree with the assessment of Dr. Heyman, the Office referral physician, that appellant did not have any physical restrictions.

In a report dated August 3, 1998, Dr. Hughes reviewed the reports of Drs. Conyers and Hemler and stated that the physical conditions described in their reports are completely

consistent with cumulative trauma disorders sustained as a result of repetitive upper extremity use, as described in his earlier reports.

Section 8123(a) of the Federal Employees' Compensation Act,[5] provides, "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." In this case, appellant's attending physician, Dr. Hughes, whose opinion is supported by the opinions of Drs. Conyers and Hemler, opined that appellant continued to experience residuals of her accepted bilateral tendinitis and left carpal tunnel syndrome and that while she could work eight hours a day, she can only do so within physical restrictions which preclude her return to her date of injury position. The Office's second opinion physician, Dr. Heyman, opined that appellant's accepted conditions had resolved without residuals and that there was no objective evidence of a need for physical restrictions in her employment or for further medical treatment. The Board finds that there is an unresolved conflict of medical opinion evidence in the record. Due to the unresolved conflict between Drs. Hughes and Heyman, the Office failed to meet its burden of proof to terminate appellant's compensation benefits.

The decision of the Office of Workers' Compensation Programs dated October 26, 1998 is hereby reversed.

Dated, Washington, DC
December 6, 2000

David S. Gerson
Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member

[5] 5 U.S.C. §§ 8101-8193, 8123(a).