U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of SERVIE LAMOTT and U.S. POSTAL SERVICE,
POST OFFICE, Dallas, TX

Docket No. 97-2788; Submitted on the Record;
Issued August 2, 1999

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON,
BRADLEY T. KNOTT

The issue is whether appellant had any disability or injury residuals after January 8, 1996, causally related to his May 19, 1980 acute lumbar muscle strain injury.

The Office of Workers' Compensation Programs accepted that on May 19, 1980 appellant, then a 44-year-old tire mechanic/repairman sustained acute lumbar strain when he stepped out of a shop wrecker and twisted his back.[1] On May 22, 1980 appellant's treating physician, Dr. Sullivan R. Bryant, an osteopath, opined that appellant could return to light duty within 30 days and return to full duty within 60 days. A medical consultation on June 12, 1980 reported that at that time appellant was 5' 11" and weighed 326 pounds, and had also been treated for uncontrolled hypertension and "minimal nerve root compression syndrome probably involving S1 root."[2] A July 28, 1980 report noted that appellant was grossly obese weighing 330½ pounds. An antinuclear antibody test was reported as being positive,[3] the presence of bilateral pleural thickening secondary to extrapleural fat was noted, mild thoracic osteophytosis was noted, as was osteoarthritis of the left elbow, an electrocardiogram revealed sinus tachycardia and nonspecific ST and T wave changes, and it was noted that nothing could be felt by palpation due to obesity. Orthopedic consultation revealed no evidence of nerve root compression or irritation from a protruded lumbar intervertebral disc, but revealed a calcified soft tissue tumor mass occupying the olecranon bursa on the left, gout involving the right knee, and degenerative arthritis of the thoracic and lumbar spine and left elbow. On December 11,

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[1] Appellant also claimed that he stepped down on some type of object which made his leg collapse, causing him to fall to the pavement and to hit the lower part of his back.

[2] The Office, however, did not accept that an S1 lumbar nerve root compression was causally related either to appellant's accepted lumbar muscle strain injury or to the low back twisting incident or fall of May 19, 1980.

[3] Suggestive of a problem with a mixed connective tissue disease; *see*, *The Merck Manual*, 15th Edition, pp. 1287-89 (1987).

1980 an examination by Dr. James L. Ough, a Board-certified orthopedic surgeon, revealed that appellant's weight was now 387 pounds and that he ambulated with a waddling gait, and stated:

> "[Appellant's] subjective complaints of pain are not matched with an abundance of findings on either physical examination or x-ray. I am sure that at one time he had sustained a painful injury. However, at this time I feel much of his pain is secondary to developed pain habits. He demonstrates no evidence of any nerve root involvement based on changes in his tendon reflexes, girth measurements or manual muscle testing. However, given [appellant's] massive size, I am sure that his back is putting up with forces which are of a greater magnitude than any back was expected to put up with…."

Dr. Ough opined that, due to appellant's obesity, it would be difficult for him to return to his previous occupation, and he recommended that appellant lose 200 pounds.

Appellant continued off work and did not lose any weight.

An Office medical adviser opined on May 12, 1981 that appellant's injury residual was "chronic lumbar strain with probably functional component, complicated by exogenous obesity."

Electromyographic (EMG) testing on October 4, 1982 of the paralumbar muscles and key muscles of both lower limbs was reported as being normal, without suggestion of any nerve root irritation. By report dated October 18, 1982, Dr. Peter Kurilecz, Jr., a Board-certified orthopedist, noted that, since his scale only went up to 300 pounds, he could not determine appellant's actual weight, that appellant voluntarily restricted his lumbar spine range of motion, that his straight leg raising was negative when sitting but that appellant restricted at 50 degrees bilaterally on supine straight leg raising, that no appreciable motor weakness was noted, and that the EMG was normal. Dr. Kurilecz opined that appellant had "no evidence of objective findings of a traumatic nature to the low back or lower extremities" and "no evidence of muscle spasm or acute nerve root irritation."

However, appellant continued to remain off work. During 1984 to 1985 he became bedridden. In 1985 appellant was diagnosed with congestive heart failure, cardiomyopathy, uncontrolled hypertension and gouty arthritis. Thereafter appellant began to experience renal failure.

By report dated May 21, 1990, appellant's treating physician, Dr. John R. Morgan, a Board-certified family practitioner, opined that, upon examination of appellant on May 21, 1990, he "found [appellant] to be totally disabled due to his injury in 1980 which resulted in a [sic] L5

radiculopathy." No further evidence from appellant's treating physicians supporting continuing injury-related disability was submitted to the record.[4]

On September 28, 1995 the Office referred appellant, together with a statement of accepted facts, the complete case record, and specific questions to be answered, to Dr. Bernie L. McCaskill, a Board-certified orthopedic surgeon.

By report dated October 26, 1995, Dr. McCaskill reviewed appellant's factual and medical history, noted that he complained of back pain aggravated by activity and somewhat relieved by rest, but noted that appellant had had no specific treatment for his back pain for the last seven years. He noted that appellant was supine on a gurney and was unable to effectively move from that position, that he was significantly overweight and unable to walk, that he had gouty arthritis affecting most joints of his body, and that he had been placed on dialysis. Dr. McCaskill noted that appellant had very limited active range of motion of the cervical spine and limited wrist motion bilaterally, that he had swan neck deformities of all digits of both hands, and that neurological examination was difficult because of appellant's gross deformities, but that there were no obvious abnormal neurological findings in either upper extremity. He noted that appellant's lower back was not visualized because of the difficulties of moving him about on a small gurney and that an active range of lumbar motion could not be evaluated. Dr. McCaskill noted that appellant had very limited passive motion of all major joints in the lower extremities and had 30 degree flexion contractures above the knees and gross deformities of both feet. He noted that because of swelling, pedal pulses could not be readily palpated, and because of his deformities, effective neurological evaluation was impossible, but that there was no evidence of obvious neurovascular compromise in either lower extremity. Dr. McCaskill reviewed diagnostic studies performed, and he diagnosed "spondylogenic lumbosacral spine pain, chronic, anatomic etiology undetermined by history" and "multiple deformities associated with gouty arthritis." He opined that appellant's present difficulties were primarily related to his gouty arthritis rather than to any type of preexistent lower back injury, based upon the extent of appellant's obvious physical deformities, and that neither additional diagnostic evaluation nor treatment was indicated or would be of predictable benefit to appellant. Dr. McCaskill answered the Office questions as follows:

> "I can identify no objective evidence that [appellant's] lumbar strain is currently active and causing total disability. I, however, do believe that [appellant] is totally disabled by his gouty arthritis. Evaluation of [appellant's] lumbar complaints is limited because of the associated severe deformities noted above.
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> "I see no objective basis to say that [appellant] is disabled from his lower back complaints.
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> "I believe that [appellant's] current disability is related to his gouty arthritis and associated deformities. I base that opinion upon [his] obvious multiple and severe deformities."

[4] However, an Office referral physician opined in 1992 that because appellant was having continued back complaints, he did not feel the 1980 injury had ceased. No medical rationale for this opinion was provided.

On November 27, 1995 the Office issued appellant a notice of proposed termination of compensation, finding that the evidence of record established that his work-related condition had ceased, based upon the well-rationalized, unequivocal report of Dr. McCaskill, who found that there was no objective evidence that appellant's lumbar strain was currently active or causing disability. The Office noted that it had attempted to contact Dr. Morgan for further clarification of appellant's condition but was advised that Dr. Morgan was no longer appellant's attending physician.

By response dated December 5, 1995, appellant objected to the proposed termination of compensation arguing that he now had end stage renal disease and required dialysis three times per week.

By decision dated January 8, 1996, the Office terminated appellant's compensation effective that date finding that the weight of the medical evidence of record established that his work-related condition had ceased. The Office found that there was no evidence supporting that appellant's contention that his end stage renal disease was causally related to his 1980 lumbar strain injury.

By letter dated January 18, 1996, appellant requested reconsideration and alleged that Dr. McCaskill did not examine or test him because he did not remove him from the ambulance stretcher. In support appellant submitted a December 16, 1995 report from Dr. Morgan who claimed that to his knowledge appellant had never been diagnosed as having lumbar strain, that the 1980 accident caused an L5 radiculopathy, and that he had diagnosed appellant as being disabled due to the L5 radiculopathy. He noted that he had treated appellant since 1990, that appellant was bed bound due to the lumbar radiculopathy, and that he continued to be disabled due to gout, renal disease and from L5 radiculopathy. Appellant also submitted a December 5, 1995 report from Dr. Steven Rinner, a Board-certified nephrologist, who indicated that appellant was totally disabled from end stage renal disease which required bed rest and dialysis three times per week.

By decision dated March 7, 1996, the Office denied modification of the January 8, 1996 decision finding that the evidence submitted was insufficient to warrant modification. The Office found that Dr. Rinner did not explain the relationship between appellant's end stage renal disease and his 1980 accepted lumbar muscular strain injury, and that Dr. Morgan based his opinion on an inaccurate history of injury, as he did not know of the 1980 to 1984 multiple lumbar muscular strain diagnoses, and he did not know that orthopedic evaluation both in July and in December 1980, and EMG testing in October 1982 all demonstrated no evidence of lumbar nerve root compression or irritation, and he omitted any rationale supporting his contentions.

By letter dated July 19, 1996, appellant requested reconsideration, and in support submitted a July 16, 1996 report from Dr. Morgan. Dr. Morgan accused the Office of manipulating facts and accused Dr. McCaskill of not doing a straight leg raising test to demonstrate appellant's L5 radiculopathy that was obviously present.[5]

[5] The Board again notes that L5 radiculopathy was not an accepted condition causally related either to appellant's

By decision dated August 26, 1996, the Office denied modification of the prior decision finding that the evidence submitted in support was insufficient to warrant modification. The Office noted that Dr. McCaskill reported that appellant had 30 degree flexion contractures above the knees, such that he could not have straightened his leg or done straight leg raising, and that a positive SLR testing result would not necessarily be related to 1980 lumbar muscular strain.

By letter dated May 15, 1997, appellant, through his representative, requested reconsideration of the August 1996 decision, and argued that more than a soft tissue injury occurred in 1980. In support appellant submitted an April 10, 1997 report from Dr. Morgan which stated that appellant had renal failure and tophaceous gout, and had continuously had low back pain and an L5 radiculopathy since his fall in 1980, that deep tendon reflexes were diminished on the right at the knee, that right lower extremity sensation was diminished, and that straight leg raising was positive at 15 degrees and at 45 degrees on the left. Dr. Morgan opined that these results were consistent with L5 radiculopathy. He also noted that appellant had extension contractions of both lower extremities, flexion contractures of the left great toe, patent leather skin changes due to thinning and inflammation of the skin, weeping ulcerations on both feet secondary to pressure sores, and severe musculoskeletal tendinous strictures and stiffness of 150 degrees at both knees, which was very painful with flexion or extension.

By decision dated July 30, 1997, the Office denied modification of the prior decision finding that the evidence submitted was insufficient to warrant modification. The Office found that the only condition accepted by the Office was lumbar muscular strain, and that Dr. Morgan provided no rationale as to why the other reported conditions were related to the 1980 lumbar muscle strain injury.

The Board finds that appellant had no disability or injury residuals after January 8, 1996, causally related to his May 19, 1980 acute lumbar muscle strain injury.

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation benefits.[6] 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 has ceased or that it is no longer related to the employment.[7] Further, the right to medical benefits for an accepted condition is not limited to the period of entitlement to compensation for wage loss.[8] To terminate authorization for medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition that require further medical treatment.[9] The Office met its burden of proof to

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lumbar muscular strain injury or to the May 19, 1980 incident.

[6] *Harold S. McGough*, 36 ECAB 332 (1984).

[7] *Vivien L. Minor*, 37 ECAB 541 (1986); *David Lee Dawley*, 30 ECAB 530 (1979); *Anna M. Blaine*, 26 ECAB 351 (1975).

[8] *Marlene G. Owens*, 39 ECAB 1320 (1988).

[9] *See Calvin S. Mays*, 39 ECAB 993 (1988); *Patricia Brazzell*, 38 ECAB 299 (1986); *Amy R. Rogers*, 32 ECAB 1429 (1981).

terminate both in this case, relying on the complete and well-rationalized report of Dr. McCaskill.

Dr. McCaskill reviewed appellant's complete factual and medical history, noted that appellant had had no specific treatment for his back pain for the last seven years, and noted that there was no evidence of obvious neurovascular compromise in either lower extremity. He reviewed diagnostic studies performed, diagnosed "spondylogenic lumbosacral spine pain, chronic, anatomic etiology undetermined by history" and "multiple deformities associated with gouty arthritis," opined that appellant's present difficulties were primarily related to his gouty arthritis rather than to any type of preexistent lower back injury, and opined that neither additional diagnostic evaluation nor treatment was indicated or would be of predictable benefit to appellant. Dr. McCaskill noted that he could not identify any objective evidence that appellant's lumbar strain was currently active or causing disability, and he opined that appellant's current disability was related to his gouty arthritis and associated deformities.

The Board has explained that the weight of medical evidence is determined by its reliability, its probative and convincing quality, 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.[10] In this case, Dr. McCaskill's report is highly probative because it was based upon a complete and accurate factual and medical history, a statement of facts and the complete case record, it was convincing and it was definite in its conclusions, it was based upon examination and testing of appellant to the most complete extent possible in this case, and it was well rationalized in support of his findings. Dr. McCaskill's report, therefore, is entitled to great weight

The other medical evidence of record submitted within the preceding 10 years fails to identify or support any disability or injury residuals, causally related to appellant's 1980 lumbar soft tissue muscle strain injury. The evidence reports symptoms of and disability due to L5 radiculopathy, a condition not accepted by the Office as being injury related,[11] and gouty arthritis and end stage renal failure, neither of which were demonstrated as being causally related to the 1980 lumbar muscle strain injury. None of this other medical evidence of record provides any medical rationale explaining how any of these conditions were either causally related to the 1980 muscular strain injury or to the 1980 twisting/falling incident. Consequently, the Board finds that there is no opposing medical evidence of record to support continuing disability or injury residuals, causally related to appellant's 1980 accepted lumbar muscle strain injury. Therefore Dr. McCaskill's report constitutes the weight of the medical opinion evidence of record and establishes that appellant has no continuing disability or injury residuals, causally related to his 1980 accepted lumbar muscular strain injury.

[10] *See Naomi A. Lilly*, 10 ECAB 560 (1958).

[11] The Board notes that this evidence is insufficiently rationalized to establish that appellant actually sustained L5 radiculopathy on May 19, 1980 when he twisted/fell at work, particularly in light of orthopedic evaluation and EMG testing in July 1980, December 1980 and October 1982, which all demonstrated no evidence of lumbar nerve root compression or irritation.

Accordingly, the decision of the Office of Workers' Compensation Programs dated July 30, 1997 is hereby affirmed.

Dated, Washington, D.C.
August 2, 1999

George E. Rivers
Member

David S. Gerson
Member

Bradley T. Knott
Alternate Member