U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of TARA CLAYTON and DEPARTMENT OF THE NAVY,
NAVY PERSONNEL SUPPORT DETACHMENT, Camp Lejeune, NC

Docket No. 99-186; Submitted on the Record;
Issued April 19, 2000

DECISION and ORDER

Before MICHAEL J. WALSH, WILLIE T.C. THOMAS,
BRADLEY T. KNOTT

The issue is whether the Office of Workers' Compensation Programs met its burden of proof to terminate appellant's compensation benefits as of September 12, 1998.

On May 19, 1997 appellant, then a 34-year-old personnel clerk, filed a notice of traumatic injury as a result of back injuries sustained during a fall. Appellant stopped work on May 29, 1997 and returned to limited duty at two hours a day on October 14, 1997 and three hours a day on November 24, 1997, gradually increasing her hours up to five hours a day in a limited-duty position. The Office accepted appellant's claim for cervical, lumbosacral strains and a herniated nucleus pulposus L5-S1 and paid appropriate compensation benefits.

In a report of December 5, 1997, Dr. Jeffrey L. Gross, appellant's treating physician and a Board-certified orthopedic surgeon, noted that appellant was able to tolerate three hours of work, although she continues in pain.

The Office referred appellant to Dr. Christopher S. Delaney, a physiatrist, for a second opinion evaluation. In his January 7, 1998 report, he noted the history of appellant's work injury along with her past history of a previous back injury. Dr. Delaney set forth the results of the physical examination and noted that as a result of the unusual constellation of symptoms and conflicting findings on physical exam[ination], nonorganic indicators of pain were tested. He noted that appellant complained of very significant pain with axial compression, en bloc rotation to the left, distracted straight leg raising sign, nonanatomic distribution of symptoms and significant pain posturing. Appellant had also demonstrated giveaway on motor examination. Dr. Delaney stated that appellant has had a very thorough evaluation and that he reviewed her chart along with a past and current magnetic resonance imaging (MRI) scan. He noted that appellant's recent MRI of the low back revealed a disc bulge, which he considered to be normal

in her age group and opined that it would not be causing her symptoms nor would it require any interventions. Dr. Delaney stated:

> "There is obviously a great deal of nonorganic, nonphysiologic contributors to this patient's complaints. [Appellant] is positive for virtually all of Waddell's criteria and her complaints do not fit any known anatomic patterns. She has had a very thorough workup and I would not recommend anymore diagnostic interventions. The workup she has had to date fails to demonstrate any evidence of neurologic or musculoskeletal instability.
>
> "I note with some concern this patient's previous history of being out of work for 19 months with once again, the absence of any objective evidence of injury in spite of a rather remarkably extensive evaluation.
>
> "It is clear there is symptom exaggeration here. It is not clear to me whether the patient is doing this consciously (malingering) or whether it is unconscious (somatization). It is clear to me, however, that this patient has no evidence of neurologic or musculoskeletal instability and there is no indication on her examination, which would support further diagnostic or therapeutic interventions. I would recommend this patient be allowed to return to work using back protection techniques but otherwise I see no medical justification for further limitations. If desired by all parties involved, a functional capacity evaluation could be done, but I expect this to confirm the variability in presentation and to have low validity for establishing objective work limitations.
>
> "Since I can find no evidence on my exam[ination], or in the history or previous diagnostic evaluations for injury or disease that I will be able to help with, I will not schedule this patient for a followup visit."

By letter dated January 12, 1998, the Office enclosed a copy of Dr. Delaney's January 7, 1998 report and requested that Dr. Gross's review and provide comments if his opinion differs from that of Dr. Delaney.

In a February 2, 1998 report, Dr. Gross stated that he concurred with Dr. Delaney's findings and have encouraged appellant to try and return to work. He stated that he could not explain why she continues to have the amount of pain that she is having. Dr. Delaney indicated that appellant should start back at four hours a day and then try to increase it.

In a March 25, 1998 report, Dr. Gross stated that he could not explain why appellant cannot work the eight hours. He indicated that none of the restrictions were preventative measures. A referral to a pain clinic was requested.

In an April 1, 1998 report, Dr. Gross stated that after reviewing appellant's chart, he saw no objective evidence that she could not return to her regular duty. He indicated that in the past he suggested that appellant be referred to a pain clinic as orthopedically he has nothing else to offer her.

In a June 9, 1998 report, Dr. Randy M. Schilsky, a chiropractor, noted that appellant was being seen for treatment of a lumbar radiculopathy and low back pain stemming from segmental dysfunction and lumbar disc syndrome at the L5-S1 level. He stated that although there is no frank herniation at the L5-S1 level, the patient is having scleratogenous referral of pain, which is associated with possible circumferental tearing of the annulus of the disc. Dr. Schilsky stated that this typically does not demonstrate clearly on an MRI and would explain the negative series. He further opined that appellant should not lift above shoulder level and not lift below the waist. Dr. Schilsky further opined that appellant should not return to a work status in which a transcutaneous electricial nerve stimulator unit and/or pain medication must be utilized as it would only mask symptoms and would not correct the condition. He stated that it was his experience that this will often cause the condition to progress over time leading to further disability.

In a letter dated July 21, 1998, the Office notified appellant of its proposal to terminate compensation benefits. Appellant was given 30 days in which to submit additional evidence or argument. No new evidence was submitted.

By decision dated August 24, 1998, the Office terminated appellant's compensation benefits effective September 12, 1998.

The Board finds that the Office meet its burden of proof to terminate appellant's compensation on September 12, 1998.

Once the Office has accepted a claim and pays compensation, it has the burden of proof of justifying 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 has ceased or that it is no longer related to the employment.[2]

The Board finds that the evidence of record clearly demonstrates that appellant has no further disability causally related to her work injury of May 19, 1997. The reports of Dr. Gross and Dr. Delaney show that appellant has no physical condition remaining that is causally related to the employment injury, which would prevent her from working a full 8-hour day. These physicians stated that appellant had no objective findings to support her claims of pain and ruled out any further diagnostic interventions. Dr. Delaney attributed appellant's limitations to symptom exaggeration and recommended that appellant return to work using back protection techniques but found no medical justification for further limitation. In his February 2, 1998 report, Dr. Gross concurred with Dr. Delaney's findings. Both physicians provided well-rationalized opinions, based on clinical and objective findings upon examination. These reports, taken together, show that appellant had no disability remaining due to the accepted conditions.

None of the other medical evidence of record shows any disability remaining due to these accepted conditions. Although Dr. Schilsky, a chiropractor, indicated that appellant had a

[1] *Robert C. Fay*, 39 ECAB 163 (1987).

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

possible circumferental tearing of the annulus of the disc, which could be causing her pain and opined that this condition typically does not demonstrate clearly on MRIs, the Board finds his opinion to be of no medical probative value. Section 8101(2) of the Federal Employees' Compensation Act, recognizes a chiropractor as a physician "only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist."[3] In diagnosing a possible circumferental tearing of the annulus of the disc, Dr. Schilsky did not diagnose a subluxation of the spine. His report, therefore, cannot be considered medical evidence because he did not diagnose a spinal subluxation. Therefore, the reports of Drs. Gross and Delaney are sufficient to support the Office's decision to terminate appellant's compensation.

The decision of the Office of Workers' Compensation Programs, dated August 24, 1998, is hereby affirmed.[4]

Dated, Washington, D.C.
April 19, 2000

Michael J. Walsh
Chairman

Willie T.C. Thomas
Alternate Member

Bradley T. Knott
Alternate Member

[3] 5 U.S.C. § 8101(2); *see Marjorie S. Geer*, 39 ECAB 1099, 1101-02 (1988).

[4] In addition to a duplicate copy of Dr. Schilsky's June 9, 1998 report, appellant submitted additional evidence from Dr. Schilsky on appeal. However, the Board may not review such evidence for the first time on appeal; *see* 20 C.F.R. § 501.2(c).