

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JENNIFER J. CHEN and U.S. POSTAL SERVICE,
POST OFFICE, Oakland, CA

*Docket No. 99-2013; Submitted on the Record;
Issued February 25, 2000*

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON,
A. PETER KANJORSKI

The issue is whether the Office of Workers' Compensation Programs properly terminated appellant's compensation on the grounds that she had no continuing disability resulting from the accepted work injury

On May 20, 1997 appellant, then a 30-year-old letter carrier, filed a claim for compensation alleging that she sustained an injury to her left arm, a contusion to her head and neck pain while in the performance of duty.

In a medical report dated June 2, 1997, Dr. Gary G. Gregersen, appellant's treating physician Board-certified in orthopedic surgery, stated that, upon examination appellant had "tenderness to the base of her cervical spine and the upper portion of her thoracic spine." He also noted a healed left forearm abrasion "with some tenderness still present." Dr. Gregersen stated that, "because of her acute symptoms, we will extend her disability to July 1, 1997."¹

Appellant thereupon filed claims for lost wages from August 2, 1997 to February 13, 1998.

In a medical report dated February 2, 1998, Dr. Gregersen stated that, appellant's "restrictions for duty have been listed based on her complaints of severe intractable pain, which is aggravated with any prolonged standing, turning, twisting, bending or lifting."

¹ Dr. Gregersen submitted multiple medical reports from June 2, 1997 to March 4, 1998 wherein he essentially stated that appellant had tenderness and pain to her cervical spine, both scapular borders and tenderness and pain to her thoracic and lumbosacral spine. He also noted pain in her left forearm after work and headaches on July 14, 1997. On March 4, 1998 Dr. Gregersen continued appellant's work restrictions to four hours daily casing mail at waist level with a restriction against overhead reaching and driving.

Dr. Gregersen added:

“I feel it has been fortunate to get [appellant] back to working at her level at this point with the work modifications of casing mail at waist level and no overhead reaching. She states she can tolerate these activities for no more than four hours. I am hopeful that by April 1, 1998 her symptoms will improve to the point she can return to her customary work activities.”

In an addendum to the report dated February 3, 1998, Dr. Gregersen stated:

“[Appellant] has advised that she is unable to drive due to pain [in the] cervical spine, -- therefore, work modifications include no driving till April 1, 1998.”

On February 12, 1998 appellant accepted the employing establishment’s proposed limited-duty position as a modified full-time letter carrier position, which limited appellant to a four-hour workday. The physical requirements of the job included a standing, walking and sitting restriction of no more than four hours a day, a lifting restriction of no more than ten pounds, a push/pull restriction of not more than ten pounds and restrictions against driving and reaching above the shoulder.

On February 13, 1998 the Office referred appellant, her medical records, a list of specific questions and a statement of accepted facts to an orthopedic surgeon for a second opinion examination. The Office noted that appellant had a prior history of polio with atrophy in the right leg. The Office specifically asked the second opinion physician to address whether appellant had any residuals from her work-related injury and, if so, to describe her physical limitations as a result of the injury and whether she had restrictions relating to a preexisting condition.

In a March 18, 1998 work capacity evaluation, Dr. Gregersen stated that, appellant could not work eight hours per workday due to “severe pain, both elbows, forearms, right shoulder.” He noted that, she would be able to work an eight-hour workday on April 1, 1998. Dr. Gregersen listed working restrictions including a reaching limitation of no more than four hours a day and a total restriction against reaching above the shoulder. He also limited appellant to no more than two hours repetitive movements of the wrists and elbow and a lifting restriction of no more than ten pounds.

On March 26, 1998 appellant rejected a job offer from the employing establishment, which was based on Dr. Gregersen’s work capacity evaluation. The employing establishment listed no standing, walking, sitting, twisting or driving restrictions and noted restrictions to reaching above the shoulder to no more than four hours a day and push/pull and motion restrictions of no more than two hours a day.

On March 31, 1998 the Office advised appellant that based on Dr. Gregersen’s February 2, 1998 medical report, her “condition will have improved by April 1, 1998 such that, you can increase work hours to eight hours a day. Your employing establishment has been informed of this and you will be expected to return to full-time duty when your medical restrictions expire.”

On April 2, 1998 Dr. Gregersen requested a neurological consultation for appellant based on her “continued severe pain C9, L5 sprain and headaches.” On that same day the Office’s nursing consultant advised the claims examiner that, she had advised the treating physician’s staff that the claims examiner “will authorize a neurological evaluation for appellant.”

In a medical report dated April 8, 1998, Dr. Charles R. Miller, a second opinion physician and Board-certified in orthopedic surgery, considered appellant’s history of injury and performed a physical examination. He noted that, he had reviewed Dr. Gregersen’s June 2, October 15 and December 10, 1997 reports, which established appellant’s work restrictions “based on her complaints with employment-related cervical spine and upper extremity.” Upon examination, the doctor stated that, appellant had full range of motion of the cervical spine and stated:

“[B]ut there is tenderness and pain on motion with forward flexion accomplished with the chin to the chest. Extension is to 30 degrees. Right and left lateral bending is normal at 35 degrees. Right and left rotation is normal at 70 degrees. There are no deformities or spasms.

“Upper extremities: Examination of the upper extremities reveals full range of motion with no swelling, tenderness, deformity or increased heat....

“Neurological Examination: Neurological examination of the upper extremities reveals deep tendon reflexes to be two plus and symmetrical, at biceps, triceps and brachioradialis. No motor or sensory deficits are noted. There is no atrophy. Strength is five by five.

“Thoracolumbar Spine: There is tenderness and pain on motion of the upper thoracic spine and the thoracolumbar spine but there is full range of motion. Flexion is to 90 degrees, extension is to 25 degrees, right and left lateral bending is to 35 degrees, right and left rotation is to 45 degrees. There is no spasm of deformity....”

Dr. Miller further noted that appellant’s spinal condition had been resolved and that there was no objective evidence of limitation or restriction of function, that appellant had no residuals or orthopedic condition causally related to her work-related injury and that her subjective complaints were minimal and intermittent, with no objective findings. He further stated that, appellant was capable of performing an eight-hour workday without restrictions, including no restriction regarding her ability to drive.

On May 5, 1998 the Office notified appellant that it proposed to terminate her benefits on the grounds that the weight of the medical evidence established that she no longer had residuals of her May 20, 1997 work-related injury. Appellant was advised that she had 30 days from the date of the notice to submit evidence in support of her claim.

In a medical report dated April 29, 1998, Dr. Gregersen stated that appellant was symptomatic with pain affecting her lower back and left buttock with occasional radiating pain

down her the lateral aspect of her left leg. He noted that, appellant had cervical and lumbar spine strain, chronic and symptomatic and continued her working restrictions to four hours a day.

In a medical report dated May 27, 1998, Dr. Gregersen noted that, he had reviewed Dr. Collin's neurological examination and stated that, appellant had cervical and lumbar spine strain, symptomatic. He continued appellant on her work restrictions.

In a decision dated June 8, 1998, the Office terminated appellant's benefits effective that day on the grounds that the medical evidence established that she no longer had residuals of her work-related injury.

On April 14, 1999 appellant requested reconsideration. In support of her request appellant submitted a work capacity evaluation dated June 1, 1998 from Dr. Gregersen, who stated that, appellant was limited to four hours work per day due to pain in the cervical and lumbar spine but that she would be able to work an eight-hour day beginning September 1, 1998.

In a medical report dated May 21, 1998, Dr. D. Eric Collins, a consultant and a specialist in neurology, stated that, he had examined appellant on that day. Upon examination, he stated the following:

"Neck: Decreased tilt. Palpation of tender suboccipital muscles causes pain to radiate to the head.

"Extremities: Distal impulses normal. Mildly atrophic right leg. Mildly decreased range of motion in the shoulders. Negative Tinel's.

"Back: straight leg raising to 50 degrees on the left causes pain in the left buttock, but pain is reproduced more by maneuvers to stretch the piriformis.

"Neurological examination: ... Cranial nerves: visual fields full to finger counting disks flat and sharp.... Extraocular movements full in all directions without nystagmus. Pupils equal, briskly reactive to light and near. No ptosis...."

* * *

"Impression:

"1. Cervical strain, chronic, No signs of radiculopathy.

"2. [L]eft low back strain, possible sacroilitis. This is worsened by [appellant] favoring that leg due to old poliomyelitis in the right leg.

"3. Chronic tensions headaches, secondary to concussion and cervical strain. headaches and overall pain may improve if sleep disorder is corrected."

On June 26, 1998 appellant rejected the employing establishment's job offer stating that the "limited-duty job offer is wrong. I can't drive." On June 28 and November 1, 1998 appellant filed claims for wage-loss compensation from April 15 to November 23, 1998.

In a medical report dated July 7, 1998, Dr. Gregersen stated that, appellant related that she "is able to return to work eight hours a day with desk work and casing [mail] only. She may drive her personal car one hour a day."

In a medical report dated August 17, 1998, Dr. Gregersen stated that he had examined appellant that day and that she related, "continued pain to her cervical spine, right and left scapular area was and lower back. She is working six hours a day, which she states she can tolerate." Upon examination, Dr. Gregerson noted:

"[Appellant is] able to flex to 40 [degrees], extend to 30 [degrees], rotate 30/30 [degrees] and bend [to] 20/20 [degrees] to the cervical spine. She complained of tenderness to the base of her cervical spine bilaterally. She had a full range of motion to both upper extremities but complained of pain in her cervical spine with this. Straight leg raise was 80/80 and she also complained of tenderness to her lumbosacral spine junction. Impression: Persistent cervical spine strain, symptomatic. Lumbar spine strain, symptomatic. Treatment: She will continue to work six hours a day."

Dr. Gregersen's September 14, 1998 medical report essentially repeated his August 17, 1998 report.

In a medical report dated October 12, 1998, Dr. Gregersen stated: "[T]o date there has been no physical evidence of any objective loss of function of her cervical or lumbar spine." In a medical report dated October 14, 1998, Dr. Gregersen stated that appellant "has had no objective or physical findings to support her symptoms, although they are so consistent, that ... every visit in the past she has had these complaints." In a medical report dated November 9, 1998, Dr. Gregersen stated:

"[Appellant] related "continued pain to the base of her cervical spine and discomfort to employment-related lower lumbar spine. Upon examination the doctor noted full range of motion of appellant's cervical spine with subjective complaints of pain and tenderness to the base of the cervical spine. [Appellant] has functional motion to both upper extremities."

He continued appellant on a six-hour workday limit and restricted her work to "desk work or casing only." In a medical report dated December 9, 1998, Dr. Gregersen stated that appellant's condition was permanent and stationary and that she will continue with her work modifications. He noted that he will see her on an as needed basis.

In a medical report received by the Office on April 20, 1999, Dr. Richard C. Nagle, Board-certified in neurological surgery, stated that he had examined appellant on March 18, 1999, demonstrated a familiarity with her history of injury and reported findings. He noted appellant's contemporary complaints of pain in both trapezia and intermittent pain in the left

forearm. Upon examination, Dr. Nagle reported essentially normal neck, spine alignment and neurological findings. He diagnosed appellant with mild cervical spondylosis, no evidence of cervical radiculopathy or myelopathy and a residual of polio involving the lower right extremity. Dr. Nagle noted, in response to a question from appellant's interpreter during the examination, that appellant's work-related injury "could ... have either caused her cervical arthritis or aggravated it if it preexisted and I have stated 'Yes.'" He ruled out superimposed anxiety although he also noted that "stress maybe compounding her complaints based on the way she moves her neck on examination."

In a medical report dated February 18, 1999, Dr. Steven Hammerschlag, Board-certified in radiology, stated that, appellant's cervical spine in a magnetic resonance imaging scan revealed a "mild cervical spondylotic ridging at C4-5 and slightly more prominently at C5-6. No evidence of cord compromise, mild C5-6 left foraminal stenosis."

In a merit decision dated April 21, 1999, the Office denied appellant's request for reconsideration on the grounds that the medical evidence failed to establish residuals causally related to her work-related injury.

The Board has carefully reviewed the case record and finds that the Office has met its burden of proof in terminating appellant's compensation.

Once the Office accepts a claim, it has the burden of proving that the disability ceased or lessened in order to justify termination or modification of compensation benefits. 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 disability has ceased or that it is no longer related to employment.²

In this case, Dr. Miller, the second opinion specialist, stated that upon examination appellant had full range of motion of the cervical and thoracolumbar spine and upper extremities and that she had an essentially normal neurological examination. He stated that there were no objective findings to support appellant's subjective complaints of pain. Further, Dr. Gregersen, appellant's treating physician, stated in medical reports dated October 12 and 14 and November 9, 1998 that there was no objective basis for appellant's complaints, that she had full range of motion of her cervical spine and functional motion to both upper extremities.³

Therefore, the Board finds that the weight of the medical evidence rests primarily with the opinion of Dr. Miller, the second opinion specialist, who provided a rationalized medical explanation of why the accepted condition had resolved and why appellant had no continuing

² *Patricia A. Keller*, 45 ECAB 278 (1993).

³ The Board notes that Dr. Nagle's April 20, 1999 statement that appellant's cervical arthritis could have been caused by the work-related injury is without probative value in that it is speculative and is not based on a rationalized medical opinion. The Board further notes that Dr. Collins' May 21, 1998 report merely states diagnoses without reference to appellant's ability to perform work.

disability from the condition she sustained on May 20, 1997 and is sufficient to meet the Office's burden of proof in terminating appellant's compensation.⁴

The April 21, 1999 and June 8, 1998 decisions of the Office of Workers' Compensation Programs are affirmed.⁵

Dated, Washington, D.C.
February 25, 2000

George E. Rivers
Member

David S. Gerson
Member

A. Peter Kanjorski
Alternate Member

⁴ See *Samuel Theriault*, 45 ECAB 586, 590 (1994) (finding that a physician's opinion was thorough, well rationalized and based on an accurate factual background and thus constituted the weight of the medical evidence that appellant's accepted injury had resolved).

⁵ The Board notes that since none of appellant's medical reports stated a basis for establishing a causal relationship between appellant's condition and her work-related injury, the Office properly found that no conflict of medical opinion existed and thus did not refer appellant's case record to an impartial medical specialist. See also *Gertrude T. Zakrajsek*, 47 ECAB 770 (1996).