U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JOHN A. TAKACS and DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SEVICE, Richmond, VA

Docket No. 00-757; Submitted on the Record;
Issued December 21, 2001

DECISION and ORDER

Before DAVID S. GERSON, MICHAEL E. GROOM,
BRADLEY T. KNOTT

The issue is whether the Office of Workers' Compensation Programs met its burden of proof to rescind acceptance of appellant's claim on the grounds that the injury was not sustained in the performance of duty.

On January 27, 1998 appellant, then a 46-year-old revenue agent, filed a notice of traumatic injury and claim for continuation of pay/compensation (Form CA-1). He alleged that on January 23, 1998, he bent down to search for forms and aggravated a herniated disc at L5-S1 affecting the lower back and left leg near the hip. Appellant stopped work on January 23, 1998.

Appellant provided statements and reports of his treating physicians, that showed prior to the January 23, 1998 incident, appellant had preexisting degenerative disc disease, a herniated disc at L5-S1, spondylothesis and arthritis. He also submitted a January 14, 1998 statement describing his conditions including, the herniated disc at L5-S1, arthritis of the spine and spondolosis of the spine.

In a January 26, 1998 statement, appellant indicated that he arrived at the employing establishment on January 23, 1998 at 8 a.m. and worked in the large conference room. He stated that he was eventually displaced and moved to a smaller conference room, where he was again displaced. Appellant noted that he then worked in an office and reviewed a list of forms that were needed to close a case. He took this list to get the forms from a large cabinet where the forms were kept. While searching for the forms, appellant bent forward and reached to search through a drawer and aggravated his preexisting condition. Initially, he took a Tylenol 3 with codeine and sat down, hoping the pain would subside, however, he indicated that the pain continued and he went to the medical unit and then to a doctor.

In a January 26, 1998 attending physician's report, Dr Martin Poliskin noted appellant's history of injury as reaching for a file and feeling pain in the back. Dr. Poliskin indicated that appellant had a history of back pain and disc disease at L5-S1 and diagnosed prolonged disc

disease, sciatica and spondylothesis. He checked the box "yes" to indicate that he believed the condition was caused or aggravated by appellant's employment activity and noted that it was aggravated by reaching for files. Dr. Poliskin also noted that the permanent effects were limitation of motion and back pain and indicated that appellant was not able to work.

By letter dated January 30, 1998, the employing establishment controverted appellant's claim.

In a report dated January 30, 1998, Dr. Poliskin indicated that the injury sustained on January 23, 1998 was an "exaggeration of a preexisting medical condition disc disease." He indicated that appellant was totally disabled and unable to work.

In a February 4, 1998 report, Dr. Franklyn H. Ashby, a fitness-for-duty physician, questioned the validity of appellant's claim.

In a February 5, 1998 report, Dr. Edward J. Reich, a Board-certified neurologist, stated that he first saw appellant on January 21, 1998 for a neurological consultation. Dr. Reich indicated that appellant's symptoms started in September 1997 with the onset of low back pain with radiation down the left buttock into the left leg. He stated that appellant's symptoms were not aggravated by valsalva maneuvers or bending. Dr. Reich made findings of a mild but definite, left S1 root entrapment, compression of the nerve root secondary to herniated disc at L5-S1 with the major disability factor being pain and not the neurological deficit. He indicated that the ideal treatment would be surgical excision of the herniated disc.

In a February 12, 1998 magnetic resonance imaging (MRI) scan, Dr. Jen-Fong Shen, a Board-certified neurologist, noted that this study was compared with a previous study of September 29, 1997. Dr. Shen indicated that the previous study showed a slight to moderate posterolateral herniated disc at the level of L5-S1 on the left side with slight indentation on the thecal sac. He noted that the current study showed no significant interval change of the posterolateral herniated disc at the level of L5-S1 and no other evidence of herniated disc was noted. Dr. Shen also indicated that there was no evidence of spinal stenosis and there was narrowing of the left-sided neural foramen at the level of L5-S1 due to herniated disc. He indicated that the other levels of foramena were patent. The September 29, 1997 MRI scan, showed that appellant had a large posterior and left parasagittal disc herniation at L5-S1.

In a February 13, 1998 report, Dr. Poliskin again stated that appellant was totally disabled and could not work.

By letter dated February 13, 1998, the Office requested additional factual and medical information. Appellant was allotted 30 days to provide the requested evidence.

In a February 24, 1998 report, Dr. Fariborz Nobandegani, a Board-certified neurological surgeon, noted that appellant was seen for follow-up concerning his lumbar spine. Dr. Nobandegani indicated that there were no significant changes in his signs and symptoms. He stated that an MRI scan was performed on February 12, 1998 and it did not reveal any interval changes.

In an undated report received by the Office on March 16, 1998, Dr. Poliskin indicated that the dates of examination and treatment were January 30, February 9 and March 2, 1998. His findings included lumbosacral spondylosis, lumbar disc displacement, degeneration of lumbosacral intervertebral disc, lumbago and sciatica. Dr. Poliskin diagnosed spondylolisthesis, disc prolapse, chronic back pain and sciatic neuritis. His opinion was that the incident of January 23, 1998 resulted in muscle spasms most likely caused by additional pressure being placed on a nerve from the disc prolapse. Dr. Poliskin also indicated that the spasticity of the muscles in the lower back caused increased stiffness and restriction of movement.

On March 19, 1998 the Office accepted that appellant had a temporary aggravation of preexisting degenerative disc disease. The Office placed appellant on the periodic rolls and paid appropriate compensation benefits.

By letter dated April 7, 1998, Dr. Ashby indicated that appellant's claim should not have been accepted.

By letter dated May 12, 1998, the Office advised appellant that a second opinion examination was scheduled with Dr. Ravi Tikoo, a Board-certified neurologist, on Thursday, May 28, 1998 at 3:00 p.m.

In a report dated May 28, 1998, Dr. Tikoo noted appellant's history of injury, including a preexisting herniated disc, initially diagnosed six years earlier and a history of depression for the last four years. He reviewed appellant's medical records including a 1998 MRI scan of the lumbar spine and a September 29, 1997 MRI of the same area. Dr. Tikoo noted that the September 29, 1997 MRI, revealed the same L5-S1 disc herniation as the later one. He diagnosed left-sided L5-S1 disc herniation and stated that it was his belief that an aggravation of appellant's pain occurred on January 23, 1998. Dr. Tikoo also asserted that the MRI scans before and after the injury, showed no significant intraval change of the herniated disc itself. Additionally, he indicated that he did not believe that all of the symptoms appellant was experiencing were directly related to the January 23, 1998 incident but instead were related to his underlying preexisting herniated discs. Dr. Tikoo opined that he did not believe that appellant sustained an aggravation of his preexisting condition but merely an increase in pain, as there was no change in appellant's underlying baseline pathology and stated that he did not believe that the incident of January 23, 1998, led to any additional disability of the claimant. He also noted that appellant's current disability was due to his herniated disc, which predated the incident and was unrelated to the incident of January 23, 1998. Dr. Tikoo stated that appellant could return to work in a light-duty capacity.

In a decision dated September 25, 1998, the Office rescinded its March 19, 1998 acceptance of appellant's claim.

By letter dated July 30, 1999, appellant, through his representative, requested reconsideration. He submitted a June 4, 1999 report from Dr. Poliskin, a January 12, 1999 report from Dr. Reich and an electromyogram (EMG) from Dr. Reich.

In the June 4, 1999 report, Dr. Poliskin noted that he first saw appellant on November 7, 1997 and determined that he suffered from a herniated disc at L5-S1 with no nerve damage. He

stated that he next saw appellant on January 30, 1998, at which time he reported that he hurt his back by bending over to search for files in cabinets at work on January 23, 1998. Dr. Poliskin noted that appellant's movements were restricted and he was unable to stand up from a sitting position, nor was he able to get up from his examination table without assistance. He indicated that "the incident of January 23, 1998 resulted in muscle spasms caused by additional pressure being placed on the nerve from a disc prolapse. The spasticity of the muscles in the lower back caused increased stiffness and restriction of movement." Dr. Poliskin also stated that the results of a dynamic evaluation performed by the "pain center" at the hospital for joint diseases reported a pattern of markedly elevated muscle tension with left-right asymmetrical upper trapezius and L5 paraspinal muscle surface EMG patterns during quiet standing and through a range of dynamic movements with delayed shut-off during forward flexion. Dr. Poliskin indicated that prior to the incident of January 23, 1998, an EMG performed by Dr. Kamdar, appellant's neurologist at that time, resulted in no nerve damage existing, and subsequent to the incident, an EMG performed by Dr. Reich showed nerve damage present at L5-S1, which was consistent with appellant's complaints as of January 30, 1998.

In the January 12, 1999 report, Dr. Reich indicated that he first saw appellant two days prior to the January 23, 1998 incident. He indicated that a full work up showed that appellant had a large herniated disc at L5-S1 on the left. Dr. Reich noted that on January 21, 1998, appellant indicated that his symptoms were not aggravated by bending. He indicated that appellant informed him of an incident wherein appellant bent over a filing cabinet and his symptoms became worse. Dr. Reich noted that although appellant did not note any further decrease in strength, his pain had increased in severity. He also noted that prior to the injury of January 23, 1998, appellant had been working, although not on a regular basis. This particular positioning and straining aggravated his underlying condition. Dr. Reich observed the subsequent February 12, 1998 MRI scan of the lumbar spine showing no change from the previous one. He commented that it would not be expected to show since, the disc on the first scan was already very large and herniated and subtle changes in the disc size were not apparent on the MRI scan. Dr. Reich noted the only thing that might be detected on any subsequent study would be only if there was a small bulge or a normal scan initially followed by a change. He indicated that subtle changes in herniated discs are not appreciated on scans and in order for there to have been a change, there would have to be a major change in the size of the herniated disc or an extrusion of a fragment. Dr. Reich stated that since the nerve was already injured and obviously had pressure on it from the disc, he did not require much of a change in a disc herniation to produce increased symptoms. He further opined that there was no question in his mind that there was a causal relationship between the aggravation of appellant's condition and the particular maneuver of bending over a filing cabinet to search for a record.

By merit decision dated October 13, 1999, the Office denied modification of the September 25, 1998 decision.

The Board finds that the Office did not meet its burden of proof to rescind its acceptance of appellant's claim.

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation benefits.[1] Under such circumstances, the Office must establish either that the original determination was erroneous or that the employment-related disability has ceased. In order to rescind acceptance of a claim, the Office must establish that its prior acceptance was erroneous through new or different evidence.[2]

The Board has upheld the Office's authority to reopen a claim at any time on its own motion under section 8128(a) of the Act and, where supported by the evidence, set aside or modify a prior decision and issue a new decision.[3] Pursuant to the Office's regulations, "the FECA [Federal Employees' Compensation Act] specifies that an award for or against payment of compensation may be reviewed at anytime on the Director's own motion. Such review may be made without regard to whether there is new evidence or information. If the Director determines that a review of the award is warranted (including, but not limited to circumstances indicating a mistake of fact or law or changed conditions), the Director (at any time and on the basis of existing evidence) may modify, rescind, decrease or increase compensation previously awarded or award compensation previously denied."[4] The Board has noted, however, that the power to annul an award is not an arbitrary one and that an award for compensation can only be set aside in the manner provided by the compensation statue.[5] It is well established that once the Office accepts a claim, it has the burden of justifying termination or modification of compensation.[6] This holds true where, as here, the Office later decides that it has erroneously accepted a claim for compensation.

In the present case, the Board finds that the record contains conflicting reports regarding whether appellant had a temporary aggravation of his preexisting degenerative disc disease. Appellant's physicians Drs. Poliskin and Reich supported a temporary aggravation of appellant's preexisting degenerative disc disease. On the other hand, the second opinion physician, Dr. Tikoo found that there was only a temporary aggravation of appellant's pain but not his underlying condition. The Board finds that the reports of Drs. Poliskin, Reich and Tikoo are of virtual equal weight and rationale and provide conflicting medical opinions. Based on the unresolved conflict in the instant case, the Office failed to meet its burden of proof to rescind the acceptance of appellant's claim.

The decision of the Office of Workers' Compensation Programs dated October 13, 1999 is hereby reversed.

Dated, Washington, DC

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[1] *Thomas Meyers,* 35 ECAB 381, 386 (1983).

[2] *Laura J. Womack,* 42 ECAB 528 (1991).

[3] *Eli Jacobs,* 32 ECAB 1147 (1981).

[4] 20 C.F.R. § 10.610 (1999).

[5] *Shelby J. Rycroft,* 44 ECAB 795 (1993); *Compare Lorna R. Strong,* 45 ECAB 470 (1994).

[6] *See Frank J. Mela, Jr.* 41 ECAB 115 (1989); *Harold S. McGough,* 36 ECAB 332 (1984).

December 21, 2001

David S. Gerson
Member

Michael E. Groom
Alternate Member

Bradley T. Knott
Alternate Member