U.S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of CYNTHIA MALLOY and U.S. POSTAL SERVICE,
POST OFFICE, Coppell, TX

Docket No. 00-498; Submitted on the Record;
Issued January 11, 2001

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issue is whether appellant had any disability after February 26, 1996, causally related to factors of her federal employment.

On October 2, 1995 appellant, then a 37-year-old mailhandler, filed a claim alleging that on that date she was squeezed between a pallet and a can by a forklift pushing another can and sustained back and left leg injury. Appellant was seen that date at the employing establishment occupational health clinic, was diagnosed as having thoracic strain and a left knee contusion and was returned to limited duty with no lifting over 20 pounds, no repetitive bending of the low back and no prolonged standing or walking. Appellant, however, stopped work and did not return. On February 17, 1996 appellant was removed from the employing establishment due to absent without leave/nonattendance.

Appellant submitted the following evidence in support of her claim. An October 9, 1995 employing establishment occupational health clinic report returned appellant to duty with no lifting, pushing or pulling over 15 pounds and no use of her left arm. An October 16, 1995 report from her family practitioner, Dr. Patrick L. Davis, diagnosed strain of the left shoulder and parascapular area with paresthesia and left arm pain and recommended no work for 10 days. A November 6, 1995 report stated likewise. A January 22, 1996 electromyographic (EMG) study reported no significant evidence of median or ulnar nerve entrapment and no obvious evidence of left cervical radiculopathy, but noted that appellant was extremely hard to test due to poor tolerance, poor effort and poor cooperation. A February 8, 1996 disability certificate indicated that appellant claimed that she was unable to work since October 16, 1995 and that she was scheduled to see an orthopedist. A February 26, 1996 CA-17 duty status form report from Dr. Davis noted clinical findings as "Tenderness around the left shoulder. Pain w[ith] range of motion. Decreased range of motion," and he checked "no" to the question of whether appellant

was advised to resume work. Dr. Davis checked "no" to the question of whether appellant could perform regular work and he noted appellant's work restrictions.[1]

On April 12, 1996 the Office of Workers' Compensation Programs accepted appellant's claim for back strain, thoracic strain, left shoulder strain and a left knee contusion. Her case was administratively closed on that same date with the annotation that "[a]ppropriate benefits, if any, were authorized." The record, however, contains no evidence that appellant received monetary compensation benefits for wage loss at that time.

On May 13 and 29, 1998 appellant filed CA-20a, CA-20, CA-7, CA-8 forms respectively claiming compensation for temporary total disability commencing October 15, 1995. On the May 13, 1998 attending physician's reports, Dr. Davis recounted appellant's history of October 2, 1995 crush injury, diagnosed "strain l[eft] shoulder and parascapular area with parathesis [sic] and pain l[eft] arm" and "l[eft] shoulder pain," and checked "yes" to the question of whether he believed the condition found was caused by the employment activity. Dr. Davis indicated that appellant's period of disability began on October 16, 1995 and he checked "no" to the question of whether appellant had been advised that she could return to work. Dr. Davis also checked "yes" to the question of whether appellant's disability for regular work would continue for 90 days or longer.

By letter dated May 26, 1998, appellant recounted her history and complained that she had not received pay for the 45-day continuation of pay period, had not received the sick or the annual leave she had accrued, that her insurance benefits were terminated and that she could get no medical treatment.

By letter dated June 24, 1998, the Office noted receipt of appellant's claim for compensation and advised that medical evidence establishing disability for work for the period claimed needed to be submitted.

By letter dated July 7, 1998, appellant complained to her congressional representative that her injury claim had been accepted, but that the acceptance had been ignored, that she had been unable to work since the October 2, 1995 injury and that she was unable to seek medical treatment because she had been without funds since 1995.

On July 9, 1998 the Office requested that Dr. Davis provide a medical narrative and an opinion as to appellant's current diagnoses, the causal relation with her employment, whether appellant still experienced injury-related residuals, or whether her injury-related conditions had ceased. The Office also inquired as to the date appellant was released to return to full or restricted duty.

In response to the congressional inquiry, the Office acknowledged that appellant's injury claim had been accepted and it advised that "[a]ppropriate benefits, if any, were authorized and

[1] These restrictions included no lifting, no reaching above the shoulder, no pushing and pulling, sitting and standing for 8 hours per day continuously, walking for 6 hours per day intermittently, bending, stooping, twisting and simple grasping with the right hand for 4 hours per day intermittently and kneeling for 3 hours per day intermittently.

[her] case file administratively closed the same date." The Office also stated that periods of disability had to be supported by medical evidence substantiating disability for work, that the medical evidence of record revealed that appellant had not been seen by a physician since February 7, 1996 until May 13, 1998 and that there was no bridging medical evidence linking her current condition to her October 2, 1995 employment injury. The Office noted that, while the case record did contain minimal threshold medical evidence to support some disability in 1995, it was not sufficient to support disability for the entire period.

By report dated August 17, 1998, Dr. Davis noted appellant's history of treatment through January 26, 1996 when he had referred appellant to an orthopedic surgeon and indicated that her diagnoses were strain of the left shoulder and left parascapular area with pain involving the left arm.

In an August 11, 1998 report, Dr. Bruce S. Hinkley, a Board-certified orthopedic surgeon, noted appellant's history of an October 2, 1995 injury when she was pinned between some equipment, noted her complaints of spinal axis pain radiating into the proximal left upper extremity and into the entire left lower extremity, and indicated that appellant's walking tolerance was one block, that she could not carry groceries nor handle a gallon of milk in and out of the refrigerator, that she did not sleep through the night even with medication and that her pain was increased with exercise, sitting and forward bending. Dr. Hinkley noted that physical examination revealed a left-sided C6 hypesthesia with weakness in deltoid, biceps and wrist flexor function, that she had L4 through S1 hypesthesia on the left which corresponded to her weakened plantar flexion and dorsiflexion in that area and that her ankle reflexes were symmetrically depressed. He opined that appellant was severely impaired in terms of activities of daily living and opined that he would certainly relate her current condition to the injury on October 2, 1995. Dr. Hinkley opined that appellant was unable to work at that time.

On September 2, 1998 the Office referred appellant, together with a statement of accepted facts and questions to be addressed,[2] for a second opinion evaluation to Dr. John A. Sazy, a Board-certified orthopedic surgeon.

By report dated October 13, 1998, Dr. Sazy reviewed appellant's history of injury and current complaints, provided physical examination results, noted negative straight leg raising tests, normal sensory exams of the upper and lower extremities and normal reflexes of the upper and lower extremities, noted Waddell's signs were positive for five out of five tests and diagnosed "[n]onorganic exam[ination] with nonanatomic symptomatology." He opined that appellant could return to full duty with no restriction, but then recommended that she have magnetic resonance imaging (MRI) of her back, neck and shoulder prior to returning to work "just to make sure that there is no anatomic pathology."

In a report dated May 27, 1999, Dr. Hinkley noted appellant's continuing complaints of neck, back and extremity pain, noted that no new objective diagnostic studies had been obtained

[2] In the statement of accepted facts, the Office noted only "thoracic strain, a left knee contusion and a left shoulder strain" as appellant's accepted conditions and noted no period of disability.

since her previous visit since they were denied by the Office, noted that her physical examination remained essentially unchanged and opined that appellant was not able to work at that time.

The Office then determined that a conflict in medical opinion evidence existed between Drs. Hinkley and Sazy and on December 28, 1998 it referred appellant to Dr. Craig R. Duhon, a Board-certified orthopedic surgeon, for an impartial medical examination on January 12, 1999 to resolve the conflict. Appellant was examined by Dr. Duhon on January 12, 1999, but he did not prepare a report answering the Office's questions as he claimed that he never received the packet with the case file, questions for determination, or appointment letter dated December 28, 1998. The Office resent the packet on February 17, 1999 and although Dr. Duhon's office said on March 25, May 13 and 28, 1999 that a narrative addressing the Office questions would be prepared, the Office decided to refer appellant to another impartial medical examiner for another impartial medical examination.

On June 17, 1999 the Office referred appellant, with a statement of accepted facts and questions to be addressed, for an impartial medical examination to Dr. Juan J. Capello, a Board-certified orthopedic surgeon.

Appellant was seen by Dr. Capello on July 19, 1999, he diagnosed "lumbar pain syndrome without evidence of radiculopathy or motor or sensory dysfunction," and Dr. Capello recommended that further objective testing be performed before he could answer the Office's questions.

A July 21, 1999 MRI report was noted as revealing a minimal disc bulge at L4-5, and mild facet and ligament flavum hypertrophy at L3-4 and L4-5 causing at most borderline acquired spinal stenosis at L3-4.

A July 21, 1999 functional capacity evaluation (FCE) provided the following assessment:

> "According to test results, [appellant] gave submaximal effort during testing; 64 percent of testing was inconsistent (9 out of 14 tests). Clinical support of a long thoracic nerve injury was not found during manual muscle testing of the serratus anterior in supine and standing were both negative. [Appellant] demonstrated ability to lift in the sedentary level. [Appellant] demonstrated labored movement for bending, squatting and walking which does not correlate with her present diagnosis and right upper extremity capacity."

The examiner opined that the FCE results found did not appear to be indicative of appellant's true functional capacity.

On August 11, 1999 the Office advised appellant that she had been paid compensation for disability for the period October 15, 1995 to February 26, 1996, which equated with approximately 18 weeks of compensation. It then explained how that amount had been calculated.

In an August 16, 1999 report, nerve conduction study results were noted as follows: "The left median and ulnar nerve motor and sensory latencies, amplitudes and nerve conduction

velocities were all normal." EMG of the left upper extremity was also determined to be normal. However, "abnormalties seen were limited to the left serratus anterior muscle, which showed findings of denervation and are compatible with a left long thoracic nerve injury."

By report dated August 23, 1999, Dr. Duhon responded to the Office questions regarding his impartial medical examination of appellant, noting that her diagnosis was "thoracic strain, rule out cervical radiculopathy," opined that "her condition was caused by the accident of October 2, 1998, as her symptoms began immediately after this accident," opined that "residuals of the accepted conditions have not ceased," and opined that appellant "could be released to return to light duty as of January 12, 1999."

By report dated August 24, 1999, Dr. Capello noted that it was very difficult to accurately assess what appellant could and could not do as she gave submaximal effort, noted her positive Waddell's inappropriate responses and opined that she should be able to do at least sedentary work duties. He opined that appellant did have "a long thoracic nerve injury. Since this happened in 1995, more than likely, this is a permanent disability related to the anterior serratus muscle on the left side." Dr. Capello noted, however, that this condition usually did not cause much of a functional disability and only causes winging of the scapula when one pushed hard. He answered the Office questions noting that there was no reason why appellant could not work an 8-hour day in a sedentary capacity; Dr. Capello indicated appellant's physical activity limitations, diagnosed "lumbar pain syndrome [and] bursitis of the left shoulder with the possibility of a rotator cuff tear," and opined that appellant's low back pain problems should have resolved by now, but that the "left shoulder problem is still ongoing." He reiterated that appellant should be able to do sedentary work, but that she needed to be treated for her left shoulder.

By decision dated September 17, 1999, the Office denied appellant's claim for compensation for the period from February 27, 1996 to the present as the medical evidence of record did not support that her disability was due to the October 2, 1995 injury. The Office found that the weight of the medical evidence established that appellant was not totally disabled for the period claimed.

The Board finds that the Office failed to meet its burden of proof to terminate appellant's monetary compensation benefits.

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation benefits.[3] 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.[4] The fact that the Office accepts an appellant's claim for a specified period of

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

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

disability does not shift the burden of proof to appellant. The burden of proof is on the Office with respect to the period subsequent to the date when compensation is terminated or modified.[5]

In this case, the Office accepted that appellant's October 2, 1995 employment injury resulted in back strain, thoracic strain, left shoulder strain and left knee contusion. The Office authorized compensation for temporary total disability for the period October 15, 1995 to February 26, 1996. The Office, however, ostensibly concluded that the effects of these conditions ceased by February 26, 1996 based, apparently, upon a February 26, 1996 CA-17 duty status form report from Dr. Davis, appellant's treating physician, who noted clinical findings as "[t]enderness around the left shoulder. Pain w[ith] range of motion. Decreased range of motion," who checked "no" to the question of whether appellant was advised to resume work and who checked "no" to the question of whether appellant could perform regular work, but who indicated that appellant could perform sitting and/or standing for eight hours per day continuously, walking for six hours per day intermittently, bending, stooping twisting, and simple grasping with the right hand only for four hours per day intermittently and kneeling for three hours per day intermittently, but with no lifting, no reaching above the shoulder, no pushing and pulling.

Once the Office determined that the medical evidence submitted by appellant was sufficient to establish that her employment incident of October 2, 1995 caused her back strain, thoracic strain, left shoulder strain, and left knee contusion and her disability for employment, the Office should have developed the medical evidence to determine the duration and extent of appellant's employment-related disability.[6]

The Board finds that the February 26, 1996 form report from Dr. Davis is not sufficiently comprehensive, detailed or well rationalized to meet the Office's burden of proof to terminate monetary compensation entitlement effective that date and finds that it does not provide any opinion on the duration or extent of appellant's accepted conditions. Further, the Board notes that Dr. Davis' February 26, 1996 opinion that appellant could work eight hours per day sitting or standing, is contradicted by his later reports, as on May 13 and 29, 1998 he opined that appellant was disabled for regular work due to her October 2, 1995 injury residuals.[7]

[5] *Patrick P. Curran*, 47 ECAB 247 (1995); *George J. Hoffman*, 41 ECAB 135 (1989); *Anna M. Blaine (Gilbert H. Blaine) supra* note 4.

[6] *See Arthur Sims*, 46 ECAB 880, 886 (1995); *George J. Hoffman*, *supra* note 5 at 141.

[7] The Board notes that Dr. Hinkley's August 11, 1998 and May 27, 1999 narrative reports also support that appellant has injury-related residuals and is unable to work and that Dr. Duhon, the first impartial medical examiner, agreed in part, finding that appellant's injury-related residuals had not ceased, but that she could be released to light duty as of January 12, 1999.

In view of the foregoing, the Board finds that the weight of the medical evidence currently or record fails to support that appellant's employment-related disability ceased as of February 26, 1996, the date the Office terminated her compensation benefits.[8]

Accordingly, the decision of the Office of Workers' Compensation Programs dated September 17, 1999 is hereby reversed.

Dated, Washington, DC
January 11, 2001

Michael J. Walsh
Chairman

David S. Gerson
Member

Willie T.C. Thomas
Member

[8] The Board notes that on August 24, 1999 the second impartial medical examiner, Dr. Capello, also identified ongoing residuals of appellant's left shoulder condition which affected her ability to perform work and which required further medical intervention and which, therefore, did not support that her period of disability ceased as of February 26, 1996.