United States Department of Labor
Employees' Compensation Appeals Board

P.B., Appellant	)	
and	)	**Docket No. 13-879**
	)	**Issued: September 26, 2013**
DEPARTMENT OF THE TREASURY, BUREAU OF ENGRAVING & PRINTING, Fort Worth, TX, Employer	)	

Appearances:
Thomas S. Harkins, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On March 4, 2013 appellant, through counsel, filed a timely appeal from a September 17, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether OWCP met its burden of proof to terminate appellant's medical benefits effective September 22, 2012 on the grounds that he had no residuals of the accepted temporary aggravation of lumbar degenerative disc disease.

On appeal appellant's attorney asserts that a cervical condition was also caused by the August 14, 2009 employment injury and that appellant continues to be disabled due to the

[1] 5 U.S.C. §§ 8101-8193.

accepted lumbar condition. He further asserts that the opinion of the referee examiner constituted stale medical evidence.

FACTUAL HISTORY

On August 18, 2009 appellant, then a 52-year-old currency examiner and exchanger, who filed a traumatic injury claim alleging that on August 14, 2009 he injured his lower back and left leg at work when he was bending and stooping to break seals.[2] He stopped work until August 18, 2009.

Reports with illegible signatures dated August 14, 2009 noted the history of injury and that appellant had a history of multiple back injuries. Lumbar pain and radiculopathy were diagnosed. In reports dated August 17, 2009, Dr. John D. Diamond, a Board-certified family physician, noted a history of constant low back pain and decreased lumbar range of motion since the August 14, 2009 employment injury. He diagnosed lumbar strain and radiculopathy.

In an August 19, 2009 report, Dr. Jacob Rosenstein, a Board-certified neurosurgeon, reported that appellant had a past history of discectomy at L4-5 in 1999 and an anterior cervical decompression on April 15, 2005 and a posterior lumbar interbody fusion on October 10, 2000, performed by him. He reported that appellant had recurrent neck pain in 2006 and now reported chronic neck and low back pain. Dr. Rosenstein described the August 14, 2009 employment incident, stating that appellant was experiencing severe low back pain and increased neck pain. He noted physical examination findings of cervical and lumbar tenderness to palpation and decreased range of motion. Dr. Rosenstein diagnosed chronic lower back pain; lumbar facet syndrome; small fiber sensory peripheral neuropathy; chronic left S1 and right L5 radiculopathy, a C4-5 central disc protrusion, status postcervical surgery in 2005, status post lumbar surgery in 2000 and bilateral foot pain.

In reports dated August 31, 2009, Dr. Diamond again noted appellant's complaint of low back pain and reiterated his findings and conclusions. A September 11, 2009 computerized tomography (CT) scan study of the lumbar spine demonstrated a solid L4-5 fusion, moderately advanced L5-S1 disc and facet arthrosis, and L2-3 and L3-4 bulging. A September 14, 2009 CT scan study of the cervical spine demonstrated a solid C4-6 fusion, moderate C4-5 bulging and a right C6-7 herniation.

On September 28, 2009 Dr. Rosenstein reported a new left C6-7 disc herniation. Dr. Diamond continued to submit reports. He noted that appellant had reported lower extremity pain since 2006 to 2007 and constant neck pain since 2005 but that the August 14, 2009 employment injury caused severe pain from the neck, extending down the full length of the spine. Dr. Diamond reiterated his findings and conclusions. In a December 2, 2009 report, Dr. Rosenstein indicated that appellant was involved in a motor vehicle accident on October 13, 2009 when he was rear-ended and that his low back and neck pain had increased since the

[2] Cheryl A. Moore, manager of the workers' compensation branch of the employing establishment, indicated that, at the time of the August 14, 2009 incident, appellant had worked light duty for quite some time due to a preexisting cervical and lumbar conditions. Appellant did no lifting and only bent to take a strap (like a belt) off a load. Ms. Moore stated that appellant did not report problems with his neck at the time of the August 14, 2009 incident.

August 14, 2009 employment injury with neck pain radiating into his left arm, occasional numbness in both arms, increased pain turning his head side-to-side, stabbing pain in his low back with pain and numbness in both legs. He repeated his diagnoses and recommended continued conservative care.[3]

In an October 5, 2009 report, Dr. Marianne Cloeren, Board-certified in occupational and internal medicine, noted her review of the medical record for the employing establishment. She indicated that appellant had a history of both cervical and spinal fusions and a history of chronic neck and back pain. Dr. Cloeren stated that appellant was working modified duty on August 14, 2009 and was not engaged in lifting. She opined that appellant had a lumbar musculoskeletal strain caused by the August 14, 2009 incident.

On December 14, 2009 OWCP accepted that appellant had a temporary aggravation of lumbar degenerative disc disease. Dr. Rosenstein performed a lumbar facet injection on January 14, 2010. He and Dr. Diamond continued to submit reports describing appellant's cervical and lumbar condition.

In April 2010 OWCP referred appellant to Dr. John A. Sklar, a Board-certified physiatrist, for a second-opinion evaluation. In a May 6, 2010 report, Dr. Sklar noted that appellant had a long history of neck and back problems and had current complaints of radiating neck and right shoulder pain and low back pain. He provided examination findings, noting that appellant had a normal gait and could heel and toe walk without difficulty. Cervical and lumbar range of motion was decreased and shoulder range of motion was full. There was some decreased sensation over the right upper and left lower extremity. Palpatory examination showed moderate tenderness to palpation in the right cervical paraspinals, trapezius, and right lateral forearm, and moderate tenderness to palpation in the lumbar paraspinals, gluteals and lateral thighs bilaterally.

Dr. Sklar advised that appellant's current problems appeared to be more degenerative and related to his prior surgical procedures then to any injuries that occurred on August 14, 2009, stating that he found no evidence that appellant sustained a significant injury on that date. He further noted that appellant was in a motor vehicle accident on October 13, 2009 and that this was much more likely the cause of any ongoing complaints. Dr. Sklar found no clear evidence of a significant ongoing radiculopathy on examination and opined that ongoing chronic pain complaints were due to his long-standing back and neck problems and possibly the October 2009 motor vehicle accident. Dr. Sklar found no indication for ongoing treatment or additional surgery, and that, if appellant required surgery in the future, it would be due to his prior back and neck problems or possibly the motor vehicle accident and not to any minor injuries which may have occurred on August 14, 2009.

[3] The record also contains diagnostic studies that predate the August 14, 2009 work injury. A November 24, 1999 cervical myelogram and CT scan study demonstrated disc protrusions at C4-5 and C5-6. The lumbar spine demonstrated a disc protrusion at L4-5. A July 13, 2000 CT scan study of the cervical spine demonstrated diffuse disc protrusions at C4-5, C5-6 and C6-7. A lumbar spine CT scan that day noted postsurgical changes with spondylosis at L5-S1 and a protrusion at L4-5. A lumbar spine magnetic resonance imaging (MRI) scan study on November 29, 2003 demonstrated postsurgical changes and advised that the integrity of the fusion was indeterminate. An April 8, 2005 cervical myelogram and CT scan study demonstrated disc narrowing at C5-6 and a central protrusion at C4-5.

A functional capacity evaluation dated May 11, 2010 demonstrated that appellant could perform medium-duty work and had a severe index for depression and a moderate index for anxiety. A chronic pain program was recommended. On May 13, 2010 Dr. Rosenstein noted that appellant was recovering from surgery for renal carcinoma and continued to have neck and low back pain. He reiterated his diagnoses and discussed treatment options. On May 26, 2010 Richard Slaughter, Psy.D., a licensed psychologist, performed a chronic pain evaluation. He indicated that appellant had a pain disorder associated with both psychological factors and a general medical condition and recommended a pain management program.

In a June 12, 2010 correspondence, appellant requested that his cervical condition be accepted and that his physician be changed. A July 2, 2010 lumbar myelogram and CT scan study demonstrated postsurgical changes and advanced disc degeneration at L5-S1 with annular bulging at L3-4 and facet joint arthrosis at L2-3 and T12-L1. A September 7, 2010 lumbar discogram and CT study demonstrated advanced L5-S1 disc disruption and severe concordant pain production, marked bilateral foraminal stenosis and moderate to marked left facet arthrosis. Dr. Diamond and Dr. Rosenstein continued to submit reports in which they described appellant's condition, reviewed diagnostic studies and reiterated their diagnoses.

In reports dated October 6 to December 2, 2010, Dr. Rosenstein described appellant's medical history regarding his lumbar condition. He provided examination findings for the lumbar spine, noting tenderness to palpation in the lower lumbar area with positive facet signs, a negative straight leg raise and 5/5 strength. Dr. Rosenstein diagnosed status post fusion surgery at L4-5 on October 10, 2000, opining that it was solid; L5-S1 degenerative disc disease; internal disc disruption syndrome (IDDS) at L5-S1; and lower extremity peripheral neuropathy by electrophysiological studies. He advised that appellant was a candidate for decompression surgery at L5-S1.

OWCP determined that a conflict in medical evidence had been created between Dr. Rosenstein and Dr. Sklar regarding whether appellant's cervical condition was due to the August 14, 2009 injury, whether lumbar surgery should be authorized and regarding appellant's work capabilities. It referred appellant to Dr. Robert E. Holladay, IV, a Board-certified orthopedic surgeon, for an impartial evaluation. Dr. Holladay was asked whether there were objective clinical findings to support acceptance of a cervical condition and for requested lumbar surgery and whether appellant still suffered residuals of the accepted condition.

In a December 7, 2010 report, Dr. Holladay, the referee physician, noted his review of the statement of accepted facts, and the medical record including diagnostic studies. He noted that appellant reported that he had retired and indicated that he had difficulties with activities of daily living. Physical examination demonstrated tenderness over the base of the cervical spine and decreased neck range of motion. Biceps, triceps and brachioradialis reflexes were 2+ and equal bilaterally. Motor strengths were 5/5 in both upper extremities. Appellant had a vague decreased sensation in a nondermatomal distribution in the right upper extremity. Examination of the lumbar spine demonstrated generalized tenderness and no muscle spasm and decreased lumbar range of motion. Patella and Achilles reflexes were 2+ and equal bilaterally. Motor strengths were 5/5 and sensation was intact in both lower extremities. Heel and toe walk was poor. Dr. Holladay diagnosed neck and low back pain, L4-L5 fusion, lumbar spine and fusion at C5-6. He advised that there was an absence of any objective physical examination findings.

Dr. Holladay indicated that there was no objective evidence of a structural injury to the cervical spine due to the August 14, 2009 employment injury, and that the diagnostic studies indicated that there was ongoing problems with progression of degeneration above and below the previous fusion at C5-6 in the cervical spine. He advised that, based upon the mechanism of injury initially reported, the predominant complaint was of pain in the lower back and legs, and that following this injury, there was an absence of objective examination findings and no documented evidence of radiculopathy from his review of the medical records. Dr. Holladay advised that there was no need for fusion at the cervical spine or lumbar spine, and that, based upon the history provided in the medical record, appellant's cervical spine condition was not related to the August 14, 2009 employment injury, which caused a sprain or strain that had long since resolved. He concluded that appellant's clinical complaints were more likely related to the preexisting degenerative condition.

On December 20, 2010 OWCP proposed to terminate appellant's medical benefits on the grounds that the weight of the medical evidence, characterized by the opinion of Dr. Holladay, established that he no longer had a medical condition as a result of the employment injury. Appellant, through his attorney, disagreed with the proposed termination. He submitted reports and treatment notes from Dr. Rosenstein dated January 4 to October 26, 2011 in which the physician disagreed with Dr. Holladay's conclusion. Dr. Rosenstein described appellant's medical history and examination findings. He indicated that appellant did not sustain only a strain/sprain of the lumbar spine, as that would have resolved within six weeks to three months, but that he had remained symptomatic and needed an L5-Sl posterior lumbar fusion. Dr. Rosenstein diagnosed: residual low back pain; status post October 10, 2000 fusion surgery at L4-5, which was solid; disc degeneration; disc protrusion; gas-vacuum phenomenon; bilateral foraminal stenosis, right worse than left, at L5-S1; and internal disc disruption at L5-S1.

In a pleading dated December 10, 2011, appellant's attorney asserted that a cervical condition should be accepted as employment related and that the recommended lumbar surgery at L5-S1 should be authorized. Dr. Rosenstein continued to submit reports describing appellant's lumbar condition and reiterating his diagnoses and conclusions.

On September 13, 2012 Dr. Ronald Blum, an OWCP medical adviser, who is Board-certified in orthopedic surgery, indicated that he had reviewed the medical evidence. He concluded that appellant's low back injury of August 14, 2009 had resolved with no evidence for structural change resulting from the injury, and that any sprain/strain that appellant sustained that day would have resolved in approximately six months, or by February 14, 2010.

By decision dated September 17, 2012, OWCP finalized the termination of medical benefits, effective September 22, 2012. It found that the weight of the medical evidence rested with the opinion of Dr. Holladay who performed the referee examination and advised that the accepted temporary aggravation of lumbosacral disc degeneration had resolved with no residuals.

LEGAL PRECEDENT

Once OWCP accepts a claim, it has the burden of proving that the disability has 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,

OWCP may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment. The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability. To terminate authorization for medical treatment, OWCP must establish that appellant no longer has residuals of an employment-related condition, which require further medical treatment.[4]

Section 8123(a) of FECA provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[5] When the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[6]

ANALYSIS

The Board finds that OWCP met its burden of proof to terminate appellant's medical benefits for the accepted temporary aggravation of lumbar disc disease on September 22, 2010. OWCP determined that a conflict in medical evidence had been created and referred appellant to Dr. Holladay for an impartial evaluation. Dr. Holladay was asked whether there were objective clinical findings to support acceptance of a cervical condition and for requested lumbar surgery and whether appellant still suffered residuals of the accepted condition.

As to appellant's assertion on appeal that Dr. Holladay's report constitutes stale medical evidence, his attorney cited the case of *Ruth Churchwell*, Docket No. 02-792 (issued October 17, 2002), which found that OWCP improperly relied on stale medical evidence in terminating wage-loss compensation for a refusal of suitable work under 5 U.S.C. § 8106(c). The Board notes that, unlike *Churchwell*, the medical evidence used by OWCP to justify its termination of benefits in the present case was more contemporaneous with its decision. Moreover, the present case does not involve application of the penalty provision of section 8106(c). Furthermore, *Churchwell* does not purport to set forth a particular time period in which medical evidence must be developed prior to issuance of a termination decision by OWCP.[7]

In a comprehensive report dated December 7, 2010, Dr. Holladay, the referee physician, noted his review of the statement of accepted facts, and the medical record including diagnostic studies. He provided physical examination findings and diagnosed neck and low back pain, L4-5 fusion, lumbar spine and fusion at C5-6. Regarding the accepted temporary aggravation of lumbar disc disease, Dr. Holladay advised that, based upon the mechanism of injury initially reported, the predominant complaint was of pain in the lower back and legs. He opined that following the employment injury, there was an absence of objective examination findings and no documented evidence of radiculopathy from his review of the medical records. Dr. Holladay

[4] *Fred Simpson*, 53 ECAB 768 (2002).

[5] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

[6] *Manuel Gill*, 52 ECAB 282 (2001).

[7] *T.D.*, Docket No. 10-1261 (issued January 21, 2011).

advised that there was no need for surgery of the lumbar spine. He concluded that appellant's clinical complaints were more likely related to the preexisting degenerative condition and that his work-related injury had resolved.

While appellant continued to submit additional reports from Dr. Rosenstein, the Board has long held that reports from a physician who was on one side of a medical conflict that an impartial specialist resolved, are generally insufficient to overcome the weight accorded to the report of the impartial medical examiner or to create a new conflict.[8] Dr. Rosenstein had been on one side of the conflict resolved by Dr. Holladay. Furthermore, in his reports dated January 4 to October 26, 2011, Dr. Rosenstein did not explain how the August 14, 2009 employment injury, accepted for temporary aggravation of lumbar degenerative disc disease, continued to cause appellant's low back complaints.

As noted above, in situations where there are opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[9]

The Board finds that, as Dr. Holladay provided a comprehensive, well-rationalized opinion in which he clearly advised that at the time of his examination appellant did not have residuals of the accepted temporary aggravation of lumbar disc disease, his opinion is entitled to the special weight accorded an impartial examiner and constitutes the weight of the medical evidence.[10] OWCP therefore properly terminated appellant's medical benefits for the accepted condition effective September 22, 2010.[11]

As to appellant's assertion on appeal that a cervical condition is employment related, the Board's jurisdiction extends only to the review of final decisions by OWCP.[12] OWCP has not issued a final decision regarding this aspect of appellant's claim.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

[8] *I.J.*, 59 ECAB 408 (2008).

[9] *Id.*

[10] *See Sharyn D. Bannick*, 54 ECAB 537 (2003).

[11] *Manuel Gill*, *supra* note 6.

[12] 20 C.F.R. § 501.2(c); *E.L.*, 59 ECAB 405 (2008). For final adverse OWCP decisions issued on and after November 19, 2008, a claimant has 180 days to file an appeal with the Board. *See* 20 C.F.R. § 501.3(e); *see D.G.*, Docket No. 12-770 (issued April 20, 2012).

CONCLUSION

The Board finds that OWCP met its burden of proof to terminate appellant's medical benefits effective September 22, 2012 on the grounds that the accepted temporary aggravation of lumbosacral disc degeneration had resolved.

ORDER

IT IS HEREBY ORDERED THAT the September 17, 2012 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 26, 2013
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board