# United States Department of Labor
# Employees' Compensation Appeals Board

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| **J.K., Appellant** | ) | |
| **and** | ) | **Docket No. 18-1250** |
| | ) | **Issued: June 25, 2019** |
| **DEPARTMENT OF LABOR, MINE SAFETY & HEALTH ADMINISTRATION, Hibbing, MN, Employer** | ) | |

*Appearances:*
*Appellant, pro se*
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

## ***JURISDICTION***

On June 6, 2018 appellant filed a timely appeal from a March 13, 2018 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.[2]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the March 13, 2018 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

## ***ISSUE***

The issue is whether OWCP properly terminated appellant's wage-loss compensation and medical benefits, effective March 14, 2018, as he no longer had residuals or disability causally related to his accepted March 4, 2015 employment injuries.

## ***FACTUAL HISTORY***

On March 10, 2015 appellant, then a 60-year-old mine safety and health inspector (metal/nonmetal), filed a traumatic injury claim (Form CA-1) alleging that on March 4, 2015 he "struck [his] head on [a] pipe overhead while walking along the narrow side of a heater" in the performance of duty. He alleged that this injury caused minor neck pain and muscle tightening in his lower back.

By decision dated April 22, 2015, OWCP indicated that when appellant's claim was first received it appeared to be a minor injury that resulted in minimal or no lost time from work and, payment of a limited amount of medical expenses was administratively approved. It subsequently reopened the claim and accepted it for a concussion, lumbar sprain, and herniated disc at L4-5.

In a January 11, 2016 report, Dr. Amy Hilde Philips, a Board-certified family practitioner, diagnosed bulging lumbar disc, opined that appellant had reached maximum medical improvement (MMI), and released him to return to work without restrictions.

On May 10, 2017 Dr. Timothy A. Garvey, a Board-certified orthopedic surgeon, indicated that appellant was seen in follow-up for back and leg pain for first evaluation since June 2015. He was complaining of bilateral lower extremity pain. Dr. Garvey reviewed a magnetic resonance imaging (MRI) scan dated January 19, 2017 which showed disc desiccation at multiple levels and found a suggestion of a spondylolisthesis of L3 on L4. He had a tethered cord with his conus ending at the cephalad body of L2. Appellant also had at L4-5 a right-sided disc herniation with moderate stenosis and mild left lateral recess narrowing, as well. Dr. Garvey opined that appellant had symptoms compatible with a discogenic etiology. He had a disc herniation to the right at L4-5 that narrowed the lateral recess that would affect the L5 root more so than S1. On the left side, appellant had far lateral foraminal disc protrusion that appeared to contact the undersurface of the exiting L5 root. Additionally, he had a low-lying conus consistent with a tethered cord that ended at the body of L2. Dr. Garvey recommended surgical decompression with neurologic monitoring. He discussed with appellant that, if he did not improve with surgical decompression at L4-5 and L5-S1, it was possible that a detehering cord procedure would be advisable. Dr. Garvey noted that appellant had a prior surgical decompression 25 years ago, which raised the potential risk.

On May 22, 2017 OWCP received a request for authorization for surgical decompression at L4-5 and L5-S1 from Dr. Garvey.

On May 31, 2017 Dr. Kenechukwu Ugokwe, a Board-certified neurosurgeon, serving as an OWCP district medical adviser (DMA), reviewed a statement of accepted facts (SOAF) and appellant's medical history and records. He opined that the proposed decompression at L4-5 and L5-S1 with discectomy dated preservice was not causally related to the accepted medical conditions because the mechanism of injury described as "hitting his head" did not correlate with

the development of back pain in this case. Dr. Ugokwe explained that the proposed surgery was not medically necessary because the MRI scan did not show any stenosis at L4-5. He noted that there was some foraminal stenosis on the left at L5-S1, but fixing this was unlikely to cause improvement in appellant's back pain. Dr. Ugokwe disagreed with Dr. Garvey's opinion that appellant's current condition was causally related to the original work injury "because the mechanism of injury was described as hitting his head which biomechanically does not lead to back pain." He further opined that the neuropathy should not be an accepted consequential condition due to the March 4, 2015 injury because the injury did not cause the neuropathy. Dr. Ugokwe concluded that the foraminal stenosis at L5-S1 was preexistent to the injury as appellant had previously had a lumbar laminectomy and the mechanism of injury was not consistent with direct cause or aggravation of a preexisting lumbar spine condition.

On August 10, 2017 Dr. Philips opined that nothing had changed in appellant's case other than the fact that his case had been reviewed by an independent medical examiner who, in her opinion, was "not the medical equivalent peer to Dr. Garvey, who is a back specialist." She advised that he had no improvement in his symptoms and he could not safely perform in the workplace. Dr. Philips took appellant off work until he had surgery approved.

OWCP referred appellant to Dr. Masood R. Ghazali, a Board-certified clinical neurophysiologist and neurologist, for a second opinion evaluation to determine the nature and extent of his accepted employment-related conditions. In his August 14, 2017 report, Dr. Ghazali reviewed a SOAF, history of the injury, and the medical evidence of record. He conducted a physical examination and found that appellant's head and ear, nose, and throat (ENT) examination demonstrated a forward flexed posture with slight slouched position. Trigger points were noted in the craniocervical junction without palpatory hypertonicity. Cervical spine range of movement was full and normal. No bruit was heard over the carotid and supraclavicular areas. Adson's testing was negative and there was no tenderness upon palpation of the temporomandibular joint (TMJ). Examination of the thoracic spine demonstrated mild kyphosis without muscle spasm in the upper thoracic paraspinal musculature. Straight leg raising testing was negative bilaterally. Appellant was able to bend forward with mild restriction of forward flexion. Lumbar extension movements were mildly restricted as well. There was no tenderness upon palpation of the thoracolumbar fascia extending up into the thoracic fascia. Gait and station were normal. No unusual pain behaviors were noted upon the neurological examination. Examination of the cranial nerves revealed normal fundus examination and pupils were round and reactive to light. Facial movements were symmetric and hearing tested by tuning fork was symmetric. Palatal movements and tongue movements were normal. Swallowing and shoulder joint range of movement were normal bilaterally. Appellant preferred to stand and walk, citing increasing pain when he was sitting in the chair for more than 10 minutes. He was able to walk on his toes and heels without any difficulty. Appellant was able to walk in tandem both forward and backward. Romberg testing was negative. Dr. Ghazali diagnosed cervical degenerative disc disease, physical deconditioning, lumbar herniated disc without signs of radiculopathy, plexopathy, or myelopathy, chronic musculoskeletal etiology for lumbago (remote history of lumbar discectomy at L5-S1 in 1999), subjective lower extremity cramps without objective signs of nerve dysfunction, mild degree of peripheral neuropathy, cervical sprain detected on the work-related injury of January 19, 2012 (symptoms had resolved by a repeat visit dated February 6, 2012), and history of lumbar strain, resolved. He also noted left lower extremity pain and paresthesia without objective signs of neurological dysfunction, lumbosacral radiculopathy or plexopathy.

Dr. Ghazali opined that the proposed surgical procedure as recommended by Dr. Garvey was not medically necessary or causally related to the date of injury and the mechanism of injury. He concurred with Dr. Ugokwe that the proposed decompression at L4-5 and L5-S1 with discectomy was not causally related to the mechanism of injury. Dr. Ghazali explained that there were no objective signs of any dysfunction at the lower lumbar levels and fixing this issue surgically was not likely to cause improvement in the continued clinical symptomatology of back pain and lower extremity pain and radiation of subjective nature without objective dysfunction in the neurological realm. He opined that the diagnosis of idiopathic peripheral neuropathy was clearly related to loss of ankle reflexes and distal symmetric polyneuropathy noted upon electromyography (EMG) examination. Dr. Ghazali found that these findings were not directly related or as a consequence of appellant's work-related injury of 2012 or 2015. Moreover, he found that there was no evidence of lumbar spinal stenosis or lumbar spondylolisthesis as detailed in Dr. Garvey's report and also upon his own review of an MRI scan of the lumbar spine dated March 27, 2015 and objective negative EMG examination for acute or chronic radiculopathy.

By development letter dated September 18, 2017, OWCP found a conflict in the medical opinion evidence between appellant's treating physicians and the second opinion examiner regarding whether additional diagnoses of stenosis and idiopathic peripheral neuropathy should be accepted as related to the work injury and if the requested decompression surgery is medically warranted.

OWCP referred appellant to Dr. Gary Wyard, an impartial medical examiner (IME) and Board-certified orthopedic surgeon, to resolve the conflict in the medical opinion evidence. In an October 10, 2017 report, Dr. Wyard conducted a physical examination and reviewed appellant's medical history and a SOAF. He found that appellant had a scar on the midline of his back, consistent with an L5-S1 laminectomy and walked without a limp. Appellant had no start-up pain. He could walk on his toes and his heels. Appellant was able to jump and squat. He was able to forward bend and come within a foot of touching the floor with his fingertips, bending at the waist with his knees stiff. Appellant sat comfortably and got on and off the examining table without hesitation, restriction, or delay. He had no list, tilt, or splinting of his lumbar spine. Appellant had significant ischemic disease in his lower extremities and had skin plaques consistent with psoriasis. He had depressed knee and ankle reflexes and a strong extensor halluces longus, strong dorsiflexion, and plantar flexion of the ankles and knees. Strength was 5/5. Appellant had 2+ pitting edema in the forelegs and a normal gait pattern. Dr. Wyard concluded that the medical evidence did not support the surgical procedure planned by Dr. Garvey. He opined that it was not medically necessary and/or causally related to appellant's accepted conditions of sprain of the neck, herniated disc at L4-5, and concussion. Dr. Wyard noted that appellant had been found to be neurologically intact by all examiners, showing no particular focal neurological findings. He opined that the findings on MRI scan and lack of objective clinical findings did not indicate the need for a decompression at L4-5 and L5-S1. Dr. Wyard concurred with the assessments of Drs. Ghazali and Ugokwe. He explained that although appellant had an adequate trial of conservative treatment that was not enough to support the conclusion that he was a surgical candidate. Dr. Wyard concluded that appellant was a poor surgical candidate for the recommended surgery because his MRI scan findings did not show a cause and explanation for his ongoing pain, he had no focal neurological findings, and he had other confounding factors, including his history of prior back surgery, being overweight and deconditioned, and fluid retention in the lower extremities. He agreed that appellant had some stenosis, but opined that it did not rise to the

indication for surgical intervention. Dr. Wyard also noted that appellant had been diagnosed with idiopathic peripheral neuropathy and agreed with that assessment based upon the EMG, but nonetheless found that appellant had minimal clinical findings of an objective nature to support that diagnosis. Appellant had no persistent objective clinical findings documented in the medical record and Dr. Wyard agreed with Dr. Ghazali that any findings were not related or as a consequence of a 2012 or a 2015 work injury. He opined that appellant had sprain/strain-type injuries which were temporary in nature, for which there were no new objective findings. Dr. Wyard explained that these were superimposed upon a preexisting low back condition, *i.e.* prior surgery in 1995, and appellant would have had a similar diagnosis regardless of any alleged injuries of 2012 or 2015 and his subjective complaints were not supported by new objective findings or a consequential injury.

In an addendum report dated December 6, 2017, Dr. Wyard clarified his opinion that appellant did not require any additional formal treatment and lumbar/sacral injections were not medically necessary. He advised that appellant required no restrictions as a result of any work-related condition. Dr. Wyard further advised that appellant was capable of working full duty.

On January 29, 2018 OWCP issued a notice of proposed termination of wage-loss compensation and medical benefits on the basis that appellant's accepted conditions had ceased without residuals. It indicated that the weight of the medical evidence, as demonstrated by Dr. Wyard's October 10 and December 6, 2017 reports, established that appellant's employment injuries had resolved. OWCP afforded him 30 days to submit additional evidence or argument in disagreement with the proposed action.

In response, appellant submitted reports dated December 13, 2017 and February 7, 2018 from Dr. Philips who continued to diagnose bulging lumbar disc and reiterated her opinion that appellant would benefit from the proposed surgery. Dr. Philips reported that appellant's "MRI [scan] does not show the degree of abnormalities that would quantify his pain which can happen," but anticipated that during surgery "the surgeon would identify the problem not seen on MRI [scan]."

By decision dated March 13, 2018, OWCP terminated appellant's wage-loss compensation medical benefits, effective March 14, 2018. It found that the special weight of the medical evidence was represented by Dr. Wyard.

## ***LEGAL PRECEDENT***

Once OWCP accepts a claim and pays compensation, it has the burden of justifying modification or termination of an employee's benefits.[3] 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

[3] *See R.P.*, Docket No. 17-1133 (issued January 18, 2018); *S.F.*, 59 ECAB 642 (2008); *Kelly Y. Simpson*, 57 ECAB 197 (2005); *Paul L. Stewart*, 54 ECAB 824 (2003).

the employment.[4] OWCP's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[5]

The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability.[6] To terminate authorization for medical treatment, OWCP must establish that appellant no longer has residuals of an employment-related condition, which would require further medical treatment.[7]

Section 8123(a) of FECA provides in pertinent part: 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.[8] In situations where there exist opposing reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving a conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual and medical background must be given special weight.[9]

## ***ANALYSIS***

The Board finds that OWCP met its burden of proof to terminate appellant's wage-loss compensation and medical benefits, effective March 14, 2018, as he no longer had residuals or disability causally related to his accepted employment injuries.

OWCP accepted appellant's claim for concussion, lumbar sprain, and herniated disc at L4-5.

OWCP properly determined that a conflict in medical opinion existed between appellant's attending physicians, Drs. Garvey and Phillips, and Dr. Ghazali, a second opinion examiner, regarding whether the requested lumbar decompression surgery should be authorized and the extent of appellant's disability due to his employment injuries. It referred appellant to Dr. Wyard for an impartial medical examination, pursuant to 5 U.S.C. § 8123(a).

In a report dated October 10, 2017, Dr. Wyard opined that the surgical procedure planned by Dr. Garvey was not medically necessary and/or causally related to appellant's accepted conditions of sprain of the neck, herniated disc at L4-5, and concussion. He noted that appellant had been found to be neurologically intact by all examiners, showing no particular focal neurological findings, and the MRI scan findings and objective clinical findings did not indicate the need for a decompression at L4-5 and L5-S1. Dr. Wyard also explained that the MRI scan

[4] *See I.J.*, 59 ECAB 524 (2008); *Elsie L. Price*, 54 ECAB 734 (2003).

[5] *See J.M.*, 58 ECAB 478 (2007); *Del K. Rykert*, 40 ECAB 284 (1988).

[6] *See T.P.*, 58 ECAB 524 (2007); *Kathryn E. Demarsh*, 56 ECAB 677 (2005).

[7] *See James F. Weikel*, 54 ECAB 660 (2003).

[8] 5 U.S.C. § 8123(a). *See R.C.*, 58 ECAB 238 (2006); *Darlene R. Kennedy*, 57 ECAB 414 (2006).

[9] 20 C.F.R. § 10.321; *see V.G.*, 59 ECAB 635 (2008).

findings did not show a cause and explanation for appellant's complaints of ongoing pain. Dr. Wyard agreed with Dr. Ghazali that any findings were not related or as a consequence of a 2012 or a 2015 work injury. He opined that appellant had sprain/strain-type injuries which were temporary in nature, for which there were no new objective findings. Dr. Wyard explained that these were superimposed upon a preexisting low back condition, *i.e.* prior surgery in 1995, and appellant would have had a similar diagnosis regardless of any alleged injuries of 2012 or 2015 and his subjective complaints were not supported by new objective findings or a consequential injury. In an addendum report dated December 6, 2017, Dr. Wyard clarified his opinion that appellant was capable of working full duty as he required no restrictions as a result of any work-related condition.

The Board finds that Dr. Wyard's opinion represents the special weight of the medical evidence and that OWCP properly relied on his opinion in terminating appellant's wage-loss compensation and medical benefits. Dr. Wyard had full knowledge of the relevant facts and evaluated the course of appellant's condition. Dr. Wyard is a specialist in the appropriate field. His opinion is based on proper factual and medical history and his report contained a detailed summary of this history. Dr. Wyard addressed the medical records to make his own examination findings to reach a reasoned conclusion regarding appellant's employment-related injuries.[10]

The remaining evidence submitted prior to OWCP's termination of appellant's wage-loss compensation and medical benefits is insufficient to overcome the special weight afforded to Dr. Wyard as the IME. Appellant submitted a report dated December 13, 2017 from Dr. Philips repeating her diagnosis of bulging lumbar disc and reiterated her opinion that appellant would benefit from the proposed surgery. However, as Dr. Philips was on one side of the conflict resolved by Dr. Wyard, her reports are insufficient to create a new conflict in medical opinion or to overcome the special weight properly accorded to Dr. Wyard.[11]

Thus, the Board finds that OWCP properly terminated appellant's wage-loss compensation and medical benefits, effective March 14, 2018.

## ***CONCLUSION***

The Board finds that OWCP properly terminated appellant's wage-loss compensation medical benefits, effective March 14, 2018, as he no longer had residuals or disability causally related to his accepted March 4, 2015 employment injuries.

[10] *See Michael S. Mina*, 57 ECAB 379 (2006) (the opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion are facts, which determine the weight to be given to each individual report).

[11] *Id.*

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the March 13, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 25, 2019
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board