

between his knee pain and work factors on July 1, 1995.¹ The Office accepted his claim for right knee sprain and chondromalacia. On October 2, 1997 appellant underwent authorized arthroscopic surgery and an osteochondral autograft to the medial condyle. On January 7, 1999 the same authorized procedure was performed on appellant's left knee. The Office later accepted left knee sprain, temporary aggravation of the medial femoral condyle and chondromalacia for the left knee. Appellant returned to work as a modified letter carrier with permanent restrictions on October 4, 1999. Authorized arthroscopic surgery and debridement was performed on appellant's right knee on December 14, 2000 and on his left knee on February 8, 2001.

After surgery appellant received regular pain management treatments from Drs. Sanford Kunkel and Bianca Ainhorn, both attending Board-certified orthopedic surgeons, for chronic knee and low back pain. In a May 18, 2001 report, Dr. Kunkel stated that appellant completed a functional capacity examination and his work restrictions included lifting 20 pounds occasionally, 10 pounds frequently and pushing and pulling 45 pounds occasionally. He found that appellant had a permanent impairment of 10 percent of the lower extremities or 5 percent for each leg and appellant received a schedule award in this amount. Appellant's pain daily medication included 20 milligrams (mg.) of Oxycontin and 5 mg. of Percocet.

On October 31, 2001 appellant returned to work as a modified letter carrier consistent with his medical restrictions. In a December 18, 2001 report, Dr. David Fisher, an attending Board-certified orthopedic surgeon, stated that appellant's symptoms included pain more in the left than right knee, especially after work and at night. He noted that appellant had crepitation and grinding in both knees and occasional buckling when he walks. Dr. Fisher stated that appellant worked an eight-hour shift at the employing establishment with modified duties that required occasional sitting and standing. He diagnosed degenerative articular changes within the knees and early symptoms of arthritis. Dr. Fisher recommended continued conservative treatment and cortisone shots in both knees. On January 30, 2002 the Office found that appellant had no loss of earnings and terminated wage-loss compensation.

In a February 1, 2002 report, Dr. Fisher stated that the cortisone injections gave appellant considerable relief from pain for about five weeks, but the symptoms have returned, particularly on the left side where appellant was having some instability. He injected both knees with cortisone to temporize the systems and took appellant off work for two weeks, until February 18, 2001. On February 8, 2002 appellant filed a notice of recurrence of total disability noting that the pain and swelling continued in his knees, he had limited mobility and that he would be off work until February 18, 2002. In a February 12, 2002 letter, the Office requested more information. No further evidence was submitted. In an April 18, 2002 decision, the Office denied the claim finding the medical evidence insufficient to establish a recurrence of total disability between February 4 to 18, 2002. In an undated letter received on October 2, 2002 appellant wrote that his job had not changed but the pain was getting worse. Appellant stated that he did not have to be doing anything to be in extreme pain and his knees were real weak and giving out and sometimes needs a cane to walk.

¹ On August 12, 1996 appellant also had filed a notice of traumatic injury and claim for compensation (Form CA-1) for pain in his right knee.

Appellant requested a hearing that was held on October 30, 2002. At the hearing appellant testified that he had five knee surgeries and though he returned to work he never stopped receiving treatments for pain. Appellant stated that his modified duties did not change prior to stopping work and when he resumed working on February 18, 2002 his condition had not improved, but he just went back to work and dealt with the pain. In support of his claim, appellant submitted an October 29, 2002 form report from Dr. Fisher, that said appellant was placed off work from February 4 to 18, 2002, secondary to bilateral knee injections, to allow for his flare-up to calm down and to diminish pain and swelling. Appellant also submitted reports dated May 9 and October 7, 2002, from Dr. Fisher, in which he stated that appellant needed knee replacements.

In a January 28, 2003 decision, the Office hearing representative affirmed the Office's April 18, 2002 decision, finding that the medical evidence lacked sufficient rationalization. Appellant requested reconsideration and submitted a June 4, 2002 report from Dr. Ainhorn, a January 15, 2003 report from a Thomas K. Spindler, a physicians' assistant, a March 3, 2003 report from Dr. Fisher and a March 19, 2003 report from Dr. Patrick M. Kortebein, an orthopedist. None of these reports except the March 3, 2003 report, discuss the relationship of appellant's condition to his accepted injury. In his March 3, 2003 report, Dr. Fisher stated that appellant had a history of osteoarthritis in his knees and his symptoms were increased by work activities including walking, bending, lifting, carrying and twisting on his legs while moving mail. In a May 27, 2003 decision, the Office denied reconsideration.

The Board notes that further medical evidence was submitted after the Office's May 27, 2003 decision and the Office issued a decision dated July 2, 2003, after appellant filed his appeal with the Board on June 10, 2003. Following the docketing of an appeal on the same issue with the Board, the Office does not have jurisdiction to render a further decision regarding a case on appeal until after the Board relinquishes its jurisdiction. The July 2, 2003 decision by the Office is, therefore, null and void.²

LEGAL PRECEDENT -- ISSUE 1

An individual who claims a recurrence of disability due to an accepted employment-related injury has the burden of establishing by the weight of the substantial, reliable and probative evidence that the disability, for which compensation is claimed is causally related to the accepted injury.³ This burden includes the necessity of furnishing medical evidence from a physician, who on the basis of a complete and accurate factual and medical history, concludes that the disabling condition is causally related to the employment injury and supports that conclusion with sound medical rationale.⁴ Where no such rationale is present, medical evidence is of diminished probative value.⁵

² See *Jimmy W. Galetka*, 43 ECAB 432, 433-44 (1992).

³ *Charles H. Tomaszewski*, 39 ECAB 461, 467 (1988); *Dominic M. DeScala*, 37 ECAB 369, 372 (1986).

⁴ *Mary S. Brock*, 40 ECAB 461, 471-72 (1989); *Nicolea Bruso*, 33 ECAB 1138, 1140 (1982).

⁵ *Michael Stockert*, 39 ECAB 1186, 1187-88 (1988).

An award of compensation may not be based on surmise, conjecture or speculation. Neither the fact that appellant's claimed condition became apparent during a period of employment nor his belief that his condition was aggravated by his employment is sufficient to establish causal relationship.⁶

When an employee, who is disabled from the job he held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence of record establishes that he can perform the light-duty position, the employee has the burden to establish by the weight of the reliable, probative and substantial evidence a recurrence of total disability and show that he cannot perform such light duty. As part of this burden the employee must show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the light-duty job requirements.⁷

However, it is well established that proceedings under the Federal Employees' Compensation Act are not adversarial in nature and while the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence.⁸

ANALYSIS -- ISSUE 1

The Board finds this case is to be remanded for further development. Appellant testified at the hearing and submitted a statement that his job duties did not change, so to establish a recurrence appellant must show that his condition worsened as a result of his accepted injury to the point where he could no longer work. In support of his case, appellant submitted several medical reports from Dr. Fisher, an attending Board-certified orthopedic surgeon. In his December 18, 2001 report, Dr. Fisher noted that appellant works an eight-hour day that involves some walking and that appellant had crepitation, grinding and occasional buckling when he walks. In his February 1, 2002 report, Dr. Fisher noted that the cortisone injections gave appellant considerable relief from pain for about five weeks, but the symptoms returned and appellant was having some instability. He injected both knees with cortisone to temporize the systems and took appellant off work for two weeks.⁹ In his October 29, 2002 form report, Dr. Fisher noted that appellant was placed off work from February 4 to 18, 2002, secondary to bilateral knee injections to allow for appellant's flare-up to calm down and to diminish pain and swelling. In his March 3, 2003 report, Dr. Fisher stated that appellant had a history of osteoarthritis in his knees and his symptoms were increased by work activities including walking, bending, lifting, carrying and twisting on his legs while moving mail. The Board notes that the Office accepted both appellant's knee conditions and subsequent surgeries were work

⁶ See *Walter D. Morehead*, 31 ECAB 188, 194-95 (1986).

⁷ *Cynthia M. Judd*, 42 ECAB 246, 250 (1990); *Terry R. Hedman*, 38 ECAB 222, 227 (1986).

⁸ *Dorothy L. Sidwell*, 36 ECAB 699, 707 (1985); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

⁹ Appellant submitted other reports of Dr. Fisher and Dr. Ainhorn, another attending Board-certified orthopedic surgeon, from around the time he claimed his recurrence of disability began. However, these reports did not indicate that appellant's condition was due to an employment-related injury.

related and the condition Dr. Fisher treated appellant for during the time in question appears to be work related.

The Board finds that, while none of the reports of Dr. Fisher are completely rationalized, they are consistent in indicating that appellant sustained a recurrence for the period of February 4 to 18, 2002 and are not contradicted by any substantial medical or factual evidence of record. Therefore, while the reports are not sufficient to meet appellant's burden of proof to establish his claim, they raise an uncontroverted inference between appellant's claimed recurrence and the accepted work-related injury and are sufficient to require the Office to further develop the medical evidence and the case record.¹⁰

Accordingly, the case will be remanded to the Office for further evidentiary development regarding the issue of whether appellant sustained a recurrence of total disability for the period February 4 to 18, 2002. The Office should prepare a statement of accepted facts and obtain a medical opinion on this matter. After such development of the case record as the Office deems necessary, an appropriate decision shall be issued.

LEGAL PRECEDENT -- ISSUE 2

In light of the finding above the Board finds the second issue moot.

CONCLUSION

Appellant has submitted sufficient evidence to require the Office to further develop the claim.

¹⁰ See *Robert A. Redmond*, 40 ECAB 796, 801 (1989).

ORDER

IT IS HEREBY ORDERED THAT the decision by the Office of Workers' Compensation Programs dated January 28, 2003 is set aside and the case is remanded for further development consistent with this decision.

Issued: April 1, 2004
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

A. Peter Kanjorski
Alternate Member