United States Department of Labor
Employees' Compensation Appeals Board

H.J., Appellant	)	
and	)	**Docket No. 12-827**
	)	**Issued: September 4, 2012**
U.S. POSTAL SERVICE, POST OFFICE, La Puente, CA, Employer	)	

Appearances:
Appellant, pro se
No appearance, for the Director

Oral Argument August 1, 2012

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On March 5, 2012 appellant timely appealed the September 27, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP), which denied his recurrence claim. 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 the claim.

ISSUE

The issue is whether appellant's claimed recurrence beginning April 26, 2009 is causally related to his February 28, 2001 employment injury.

FACTUAL HISTORY

Appellant, a 67-year-old letter carrier, has an accepted occupational disease claim for left knee sprain, which arose on or about February 28, 2001. On April 25, 2001 he underwent arthroscopic surgery to repair a torn left medial meniscus. OWCP paid appropriate wage-loss

[1] 5 U.S.C. §§ 8101-8193.

compensation for the period April 4 to July 25, 2001. Following surgery, appellant performed light-duty work for several weeks and then resumed his regular duties effective August 29, 2001.

When OWCP accepted the claim on August 15, 2001, appellant had already undergone left knee arthroscopy for a torn medial meniscus. In accepting the claim for left knee sprain, OWCP did not specifically address whether the diagnosed meniscus tear and associated surgery were also causally related to his February 28, 2001 employment injury.[2] Despite not having formally accepted any condition other than knee sprain, it later compensated appellant for lost wages covering a four-month period that coincided with his April 25, 2001 surgery and recuperation. On May 6, 2002 appellant submitted the bill for his April 25, 2001 surgical procedure. To date, OWCP has not formally responded to his May 6, 2002 submission.

On October 6, 2009 both appellant and his HMO (Kaiser Permanente) contacted OWCP regarding authorization for additional surgery. OWCP advised him that his claim had been closed for over seven years and that he would have to file either a new claim or a claim for recurrence (Form CA-2a).

On April 15, 2010 appellant filed a claim for recurrence beginning April 26, 2009. In May 2010, he was diagnosed with severe left knee osteoarthritis and advised to undergo surgery. On June 1, 2010 Dr. Lawrence H. Albinski, a Board-certified orthopedic surgeon, performed a left total knee arthroplasty.

The medical evidence submitted in support of appellant's claimed recurrence included, *inter alia*, a May 25, 2010 report from Dr. Robert E. Sallis, appellant's treating physician, and a March 18, 2011 report from Dr. Guirguis S. Hanna, a Board-certified physiatrist.

In his May 25, 2010 report, Dr. Sallis noted a history of a work-related meniscus tear in 2001 with surgery and subsequent development of osteoarthritis.[3] He explained that appellant's current knee pain was a progression of the original injury with worsening osteoarthritis. Dr. Sallis further indicated that appellant's condition initially improved with surgery, but his symptoms had since returned and were not responsive to cortisone shots or other treatment. He also noted that appellant was awaiting knee replacement surgery.

Dr. Hanna examined appellant on February 14, 2011 for purposes of determining the cause of his current left knee condition. In his March 18, 2011 report, he noted a history of injury on February 28, 2001. Appellant was reportedly going uphill in the rain when his left foot slipped and his knee twisted. Dr. Hanna noted that appellant had undergone arthroscopic surgery on April 25, 2001, and later resumed his regular duties. Appellant's left knee pain persisted, but he was able to tolerate the pain with over-the-counter Motrin or Tylenol. Dr. Hanna further

[2] On or before August 15, 2001, the only evidence reflecting a left knee sprain consisted of two duty status reports (Form CA-17) dated April 4 and 5, 2001 from Dr. Mark A. Martinez, Board-certified family practitioner and Dr. Flora H. Johnson, Board-certified in medical malpractice, respectively. OWCP subsequently received an April 5, 2001 narrative report from Dr. Martinez wherein he diagnosed left knee medial meniscus tear. Most of the medical evidence submitted on or before OWCP's August 15, 2001 acceptance pertained to a left knee medial meniscus tear, rather than the less severe accepted condition of left knee sprain.

[3] Dr. Sallis is a Board-certified family practitioner with a subspecialty in sports medicine.

noted that appellant's orthopedic surgeon had reportedly advised appellant that he may develop arthritis. Additionally, he reported that in 2008 appellant noted a gradual worsening of his left knee pain. Appellant then returned to Dr. Sallis and received a couple steroid injections in his left knee. The injections provided only temporary relief and he was subsequently referred to Dr. Albinski, who performed a left total knee arthroplasty on June 1, 2010. Following surgery, appellant returned to part time, limited duty on January 31, 2011. When Dr. Hanna examined appellant in February 2011, he was awaiting reevaluation by his surgeon, which was scheduled for June 2011.

Dr. Hanna's diagnostic impression included left knee osteoarthritis, history of left knee arthroscopy and history of knee joint replacement. He noted that appellant continued to have weakness in the left quadriceps and diminished left knee range of motion. Dr. Hanna believed appellant might benefit from additional physical therapy to improve strength and function of the left lower limb. He also believed there was a causal relationship between appellant's February 28, 2001 injury and the development of the left knee osteoarthritis, which required total knee replacement. Dr. Hanna explained that previous meniscectomy surgery is an accepted risk factor and there is strong evidence correlating it with knee osteoarthritis. He further explained that a review of the medical literature revealed some evidence correlating knee osteoarthritis with heavy physical demand.

In a decision dated July 2, 2010, OWCP denied appellant's recurrence claim. The Branch of Hearings & Review affirmed the denial on November 10, 2010 and on September 27, 2011, it denied modification.

LEGAL PRECEDENT

A recurrence of a medical condition means a documented need for further medical treatment after release from treatment for the accepted condition or injury when there is no accompanying work stoppage.[4] A recurrence of disability means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition, which resulted from a previous injury or illness without an intervening injury or new exposure to the work environment that caused the illness.[5] This latter term also means an inability to work when a light-duty assignment specifically made to accommodate an employee's physical limitations due to his work-related injury or illness is withdrawn (except when such withdrawal occurs for reasons of misconduct, nonperformance of job duties or a reduction-in-force) or when the physical requirements of such an assignment are altered such that they exceed the employee's established physical limitations.[6] Absent a change or withdrawal of a light-duty assignment, a recurrence of disability following a return to light duty may be established by showing a change

[4] 20 C.F.R. § 10.5(y). Continuous treatment for the original condition or injury is not considered a "need for further medical treatment after release from treatment," nor is an examination without treatment. *Id.*

[5] *Id*. at § 10.5(x).

[6] *Id.*

in the nature and extent of the injury-related condition such that the employee could no longer perform the light-duty assignment.[7]

Where an employee claims a recurrence of disability due to an accepted employment-related injury, he has the burden of establishing that the recurrence of disability is causally related to the original injury.[8] This burden includes the necessity of furnishing evidence from a qualified physician who concludes, on the basis of a complete and accurate factual and medical history, that the condition is causally related to the employment injury.[9] The medical evidence must demonstrate that the accepted injury caused, precipitated, accelerated or aggravated the claimed recurrence.[10]

ANALYSIS

While Dr. Sallis' and Dr. Hanna's reports are insufficient to discharge appellant's burden of proving that his left knee osteoarthritis was causally related to his February 28, 2001 employment injury, their opinions are sufficient to require further development of the case record by OWCP.[11] Dr. Sallis opined that appellant's current knee condition was a progression of the original injury with worsening osteoarthritis. Dr. Hanna opined that there was a causal relationship between appellant's February 28, 2001 injury and the development of his left knee osteoarthritis, which required total knee replacement. Moreover, the current record does not include any rationalized medical evidence attributing appellant's osteoarthritis to some other nonindustrial cause.

OWCP has consistently questioned the existence of a causal relationship between appellant's current condition and his accepted employment injury because of the lack of medical evidence revealing bridging symptoms from 2001 to 2010. As documented in Dr. Hanna's March 18, 2011 report, appellant reported that after returning to work in 2001, his left knee pain persisted, but he was able to tolerate the pain with over-the-counter Motrin or Tylenol. This continued until 2008 when appellant noted a gradual worsening of his left knee pain, at which point he saw Dr. Sallis, who began administering cortisone injections. The absence of contemporaneous medical evidence of bridging symptoms is not proof that a causal relationship does not exist, particularly where appellant claimed to have continued to work in pain for several years with the aid of over-the-counter medication and apparently did not seek medical attention for his injured left knee.

[7] *Theresa L. Andrews*, 55 ECAB 719, 722 (2004).

[8] 20 C.F.R. § 10.104(b); *Carmen Gould*, 50 ECAB 504 (1999); *Helen K. Holt*, 50 ECAB 279, 382 (1999); *Robert H. St. Onge*, 43 ECAB 1169 (1992).

[9] *See Helen K. Holt, supra* note 8.

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.2 (June 1995).

[11] *See John J. Carlone*, 41 ECAB 354 (1989); *Horace Langhorne*, 29 ECAB 820 (1978).

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. The claimant has the burden to establish entitlement to compensation; however, OWCP shares responsibility in the development of the evidence to see that justice is done.[12]

On remand, OWCP should refer appellant to an appropriate specialist, along with the case record and a statement of accepted facts. OWCP's referral physician should provide an evaluation and a rationalized medical opinion on whether appellant's left knee osteoarthritis and total knee arthroplasty are employment related. After such further development of the case record as OWCP deems necessary, a *de novo* decision shall be issued.

CONCLUSION

The case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the September 27, 2011 decision of the Office of Workers' Compensation Programs is set aside, and the case is remanded for further action consistent with this decision of the Board.

Issued: September 4, 2012
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

[12] *William J. Cantrell*, 34 ECAB 1223 (1983).