

On appeal, appellant's representative asserted that Dr. Bernie McCaskill, a Board-certified orthopedic surgeon, was not properly selected as an impartial specialist and, as such, his opinion was not entitled to special weight regarding the issues presented.

FACTUAL HISTORY

On March 9, 2004 appellant, then a 28-year-old mail handler, injured her left foot while pushing a bulk mail container. She returned to modified duty, which she continued until her retirement in 2012.² OWCP accepted the claim for contusion of left great toe, injury to peroneal nerve, and tenosynovitis of the left foot/ankle.³

On January 10, 2013, Dr. Mike Shah, a Board-certified physiatrist, noted the history of injury and stated that appellant had developed L5 radiculitis. Left leg examination demonstrated mild swelling and decreased range of motion, with tenderness and significantly decreased strength. Lumbar spine examination showed mild tenderness, good range of motion, decreased leg strength, and equivocal range of motion. Dr. Shah noted his comparison of November 2009 and March 2012 lower extremity electrodiagnostic studies, advising that the later study showed the development of right L5 radiculitis. He requested that appellant's claim be expanded to include a consequential lumbar radiculitis, opining that this resulted from her chronic foot injuries and working on cement floors, bending, and lifting for years. On January 29, 2013 Dr. Shah reported her complaint of such severe left foot pain and weakness that she could barely walk. Examination demonstrated significant weakness with dorsiflexion and plantar flexion and appellant had an antalgic gait with sensory loss along the peroneal distribution. Dr. Shah reiterated his diagnoses and recommended therapy.

In March 2013, OWCP referred appellant to Dr. Donald M. Mauldin, Board-certified in orthopedic surgery, for a second opinion evaluation.⁴ Dr. Mauldin was specifically asked to comment as to whether she had any continuing residuals of the accepted conditions and whether the case should be expanded to include lumbar radiculitis. In an April 23, 2013 report, he described the history of injury, his review of the medical record, and appellant's complaint of constant pain since the work injury. Lower extremity examination showed a fairly normal gait with no evidence of skin discoloration of the feet, no edema and no temperature differential. Nails were well manicured and polished. Calf and forefoot circumference and circumference around the base of the nail of the great toe were equal bilaterally. Hair growth was normal.

² Appellant voluntarily retired on August 13, 2012. She received schedule awards for eight percent total impairment of the left leg: four percent on October 17, 2007; two percent on February 7, 2012; and two percent on September 12, 2012.

³ Dr. Tracey Rae Adams, a Board-certified physiatrist, performed a December 20, 2004 electrodiagnostic study of the lower extremities that demonstrated a left accessory deep peroneal nerve, an anatomic anomaly, but was otherwise normal. An October 16, 2009 left ankle magnetic resonance imaging (MRI) scan study showed mild tenosynovitis. An MRI scan of the left foot that day revealed possible mild Lisfranc's ligament sprain and mild degenerative change of the first metatarsal head. A November 2, 2009 lower extremity electrodiagnostic study was interpreted as abnormal with evidence suggesting a left peroneal neuropathy at the foot and no evidence of lumbar radiculopathy or tibial neuropathy.

⁴ Dr. Mauldin had previously seen appellant on February 23, 2005. At that time he found nothing clinically wrong with her left foot.

Dr. Mauldin found some breakaway weakness of the left great toe of no known reasoning. Passive range of motion when distracted appeared normal, yet on active range of motion appellant resisted dorsiflexion beyond approximately a neutral position on the left foot. The left ankle was grossly stable with no swelling. Dr. Mauldin diagnosed status post history of a contusion/crush, injury to the left foot with no objective documentation of any significant structural injury initially, and chronic pain complaints of the left foot. He indicated that there were no objective findings to support appellant's pain complaints or evidence that she had developed a true complex regional pain syndrome. Dr. Mauldin opined that the accepted conditions should not be expanded to include lumbar radiculitis since there was never any evidence of a structural injury to the lumbar spine and this should not have developed from her foot injury. He recommended a functional capacity evaluation (FCE) noting that, unless there was specific documentation of a foot disorder, appellant could return to full duty.

OWCP referred appellant for an FCE that was completed on April 29, 2013. The evaluation demonstrated that appellant was self-limiting with numerous activities due to complaints of severe left foot/ankle discomfort. In an addendum dated May 14, 2013, Dr. Mauldin indicated that he had reviewed the April 29, 2013 FCE and concluded that, based on his examination and the FCE results, she could return to full duty. He confirmed this opinion in an April 14, 2013 work capacity evaluation.

OWCP determined that a conflict in medical evidence had been created between Dr. Shah and Dr. Mauldin regarding whether appellant's accepted employment conditions should be expanded to include a lumbar spine condition as a consequence of the employment injury. The record includes a July 16, 2013 screen shot showing that Dr. McCaskill had been selected to perform the impartial evaluation. The record also included an OWCP Form ME023 with a certification that the medical management application (MMA) was used to select the referee physician, and a log of bypassed physicians, including bypass codes and explanations of why each physician was bypassed.⁵ On July 17, 2013 OWCP referred appellant to Dr. McCaskill.

On July 21, 2013 appellant's representative requested to participate in selecting the impartial physician. He asserted that the Texas medical board documented unprofessional conduct by Dr. McCaskill such that a new referee examination was required. He attached a June 9, 1992 order of public reprimand indicating that the Texas State Board of Medical Examiners found that Dr. McCaskill failed to practice medicine in an acceptable manner because he failed to perform adequate follow up and testing on two patients. On August 21, 2009 the Texas medical board fined Dr. McCaskill \$1,000.00 for failure to timely release medical records.

In a July 31, 2013 decision, OWCP denied appellant's request to participate in the selection of the referee physician. It found that Dr. McCaskill was properly selected to perform the referee examination, and found the 1992 and 2009 documentation regarding his qualifications were not a valid reason to show that he was not properly selected to serve as an impartial specialist in this case. Appellant was provided appeals rights. On August 24, 2013

⁵ The log indicated that Dr. Joshua Woody was bypassed based on zip code location and that Drs. James Hood, Robert Holladay, Grant McKeever, and John Steele were bypassed because appellant had previously been seen by an associate of each listed physician.

appellant's representative requested a hearing. The Branch of Hearings and Review acknowledged the request for a hearing. No further action was taken on this request.

In reports dated August 27, 2013 report, Dr. McCaskill noted the history of injury as presented by appellant, her complaint of continuous left leg and low back pain, and his review of the medical record. Physical examination demonstrated that appellant sat without obvious discomfort and moved with a somewhat slow and stiff but symmetrical gait. She could rise to her tiptoes but did not toe walk; could stand on her right heel but not on the left; did not heel walk on either leg; stood on each leg without significant pelvic tilting; and could bend, kneel, and pick up an object from the floor very slowly but without obvious difficulty. Appellant moved on and off an examination table somewhat slowly but without obvious difficulty. Direct visual inspection of her lower back was unremarkable, with no obvious muscle spasm or deformity. She showed limited back range of motion and reported that light touch over her lower back, light pressure over the apex of the head, and any passive movement of her lower back, including minimal rotation of the torso and pelvis in the same direction, caused significant pain.

Seated hidden straight leg raising on both the left and right caused no obvious discomfort, was not limited, and did not cause withdrawal. Supine straight leg raising was not evaluated. Appellant demonstrated diffuse giveaway weakness in the left leg that did not appear to be of physiologic origin and claimed that she was unable to extend her left ankle beyond 40 degrees of flexion despite the fact that her left ankle was in a neutral position when she stood. Infrapatellar reflex was 2+ on the left and trace on the right with no other abnormal neurological findings in either leg. There was no obvious swelling, atrophy, deformity or other objective evidence of a significant musculoskeletal injury in either leg, and mid thigh, mid calf, maximum ankle, and mid foot circumferences were equal bilaterally. Dr. McCaskill reported that appellant showed an inconsistent tremor of her left foot during examination.

Dr. McCaskill diagnosed left leg pain, chronic, anatomic etiology undetermined (by history); spondylogenic lumbosacral spine pain associated with right leg pain, chronic, anatomic etiology undetermined (by history); and multiple nonphysiological findings. He noted that there were no significant objective abnormal physical findings other than a relatively decreased right infrapatellar reflex which did not explain appellant's accepted left leg complaints, noting that there was no significant atrophy in either leg and that she had multiple nonphysiologic findings. Dr. McCaskill stated that previous imaging studies showed no abnormalities to explain the diffuse, persistent, and severe nature of the patient's complaints.

Dr. McCaskill recommended that, because the two electrodiagnostic studies were not in agreement, a third study be completed. This was done on September 26, 2013 by Dr. Radie F. Perry, a Board-certified physiatrist. The study demonstrated normal bilateral peroneal motor and sensory nerve conduction, normal bilateral tibial conduction with no electrophysiologic evidence of lumbosacral radiculopathy or plexopathy of the left lower extremity. In response to specific OWCP questions, Dr. McCaskill advised that there were no significant objective abnormal physical findings with regard to the accepted left leg conditions and apparent multiple nonphysiologic findings. He found no credible objective residuals that could reasonably be attributed to the March 9, 2004 employment injury.

In regard to lumbar radiculitis, appellant reported that her lower back and right lower extremity symptoms began spontaneously seven years after the accepted date of injury and because Dr. McCaskill found no credible evidence of a significant ongoing left lower extremity injury or any evidence of an injury to explain the persistence and magnitude of her complaints, he found no basis to attribute the lower back, and right leg complaints to the March 9, 2004 work injury. Dr. McCaskill concluded that there was no credible evidence that the accepted left leg conditions would prevent her from returning to her regular work. He completed a work capacity evaluation on September 28, 2013 in which he indicated that appellant could perform her usual job for eight hours daily without restriction.

In a November 1, 2013 decision, OWCP denied appellant's request to expand the claim to include a lumbar condition. On November 19, 2013 appellant's representative requested a hearing. He also reiterated his request for an explanation of the selection of Dr. McCaskill as referee physician, questioning the codes provided for the bypassed physicians. In November 20, 2013 correspondence, OWCP informed appellant's representative of the procedures used to select Dr. McCaskill and responded to his questions. Appellant's representative requested further explanation on November 29, 2013 to which OWCP explained the connection between the bypassed physician and appellant's case on December 2, 2013.

On November 25, 2013 OWCP proposed to terminate appellant's compensation benefits as the medical evidence established that she had no residuals or disability due to the employment injury.⁶

Appellant's representative disagreed with the proposed termination. He asserted that Dr. McCaskill was improperly selected as the referee physician such that his opinion was not entitled to special weight. Appellant submitted a July 24, 2013 report in which Dr. Jeffrey Fritz, a Board-certified anesthesiologist, noted her history and her complaint of bilateral foot aching and radiating low back pain with difficulty in prolonged walking and standing. Dr. Fritz advised that she had significant weakness with both dorsiflexion and plantar flexion to resistance and an antalgic gait with sensory loss along the peroneal distribution. He reviewed the October 16, 2009 left foot MRI scan study and November 2, 2009 electrodiagnostic study and concluded that appellant had a chronic work-related foot injury with an altered gait affecting her lumbar spine. Dr. Fritz recommended medication to control pain.

In a January 9, 2014 decision, OWCP finalized the termination of appellant's wage-loss and medical benefits, effective January 23, 2014, on the grounds that that she had no residuals of the accepted conditions. It found that the weight of the evidence rested with the opinion of Dr. McCaskill, the impartial specialist. Appellant's representative timely requested a hearing. He submitted a January 16, 2014 left foot MRI scan that showed a small synovial/ganglion cyst between the base of the third and fourth metatarsals and was otherwise normal.

At the hearing, held on February 20, 2014, appellant's representative reiterated that Dr. McCaskill was improperly selected as referee physician. He again disputed the bypass codes of Dr. Woody, based on location, and Drs. Hood, Holladay, McKeever, and Steele, based on

⁶ OWCP initially issued a November 4, 2013 decision terminating appellant's medical benefits. On November 22, 2013, it informed her that this decision was issued in error.

conflict. Appellant testified regarding her medical condition and the hearing representative explained the type evidence needed to establish a consequential back condition. The record was held open for 30 days.

In e-mail correspondence dated December 2, 2013 and March 14, 2014, OWCP explained to appellant that Dr. Hood and Dr. Holladay were in association with Dr. Mauldin in a medical group called Mean Corpuscular Hemoglobin Concentration (MCHC), formerly called Occupational Safety Health (OHS), and that Drs. McKeever and Steele were in a network called Churchill, in association with Dr. Tracy Adams who had previously seen appellant.

By decision dated April 14, 2014, an OWCP hearing representative found that OWCP properly denied appellant's request to participate in the selection of the referee physician, that she had not established a consequential lumbar condition, and that OWCP properly terminated appellant's medical and wage-loss benefits. She affirmed OWCP decisions dated November 1, 2013 and January 9, 2014.

LEGAL PRECEDENT -- ISSUE 1

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.⁷ The implementing regulations states that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination, and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.⁸

Congress did not address the manner by which an impartial medical referee was to be selected.⁹ Under OWCP's procedures, the Director of OWCP has exercised discretion to implement practices pertaining to the selection of the impartial medical referee. Unlike second opinion physicians, the selection of referee physicians is made from a strict rotational system.¹⁰ OWCP will select a physician who is qualified in the appropriate medical specialty and who has no prior connection with the case.¹¹

In turn, the Director has delegated authority to each district office for selection of the referee physician by use of the MMA within the intergrade federal employee's compensation system (iFECS).¹² This application contains the names of physicians who are Board-certified in

⁷ 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

⁸ 20 C.F.R. § 10.321.

⁹ *J.S.*, Docket No. 12-1343 (issued April 22, 2013).

¹⁰ Federal (FECA) Procedure Manual, Part 3 -- Medical, *OWCP Directed Medical Examinations*, Chapter 3.500.4.b (July 2011).

¹¹ *Id.* at Chapter 3.500.4.b(1).

¹² *Id.* at Chapter 3.500.4.b(6).

over 30 medical specialties for use as referees within appropriate geographical areas.¹³ The MMA in iFECS replaces the prior Physician Directory System (PDS) method of appointment.¹⁴ It provides for a rotation among physicians from the American Board of Medical Specialties, including the medical boards of the American Medical Association and those physicians Board-certified with the American Osteopathic Association.¹⁵

Under the procedure manual, a claimant may request to participate in the selection of the referee physician or may object to the physician selected under the MMA. In such instances, the claimant must provide valid reasons for any request or objection to the claims examiner.¹⁶ The right of the claimant to participate in the selection of the medical referee is not unqualified. He or she must provide a valid reason, not limited to: (a) documented bias by the selected physician; (b) documented unprofessional conduct by the selected physician; (c) a female claimant who requests a female physician when gynecological examination is required; or (d) a claimant with a medically documented inability to travel to the arranged appointment when an appropriate specialist may be located closer.¹⁷ When the reasons are considered acceptable, the claimant will be provided with a list of three specialists available through the MMA.¹⁸ If the reason offered is determined to be invalid, a formal denial will issue if requested.¹⁹

Selection of the referee physician is made through use of the application by a medical scheduler in the district office. The claims examiner may not dictate the physician to serve as the referee examiner.²⁰ The medical scheduler imputes the claim number into the application, from which the claimant's home zip code is loaded.²¹ The scheduler chooses the type of examination to be performed (second opinion or impartial referee) and the applicable medical specialty. The next physician in the roster appears on the screen and remains until an appointment is scheduled or the physician is bypassed.²² If the physician agrees to the appointment, the date and time are entered into the application. Upon entry of the appointment information, the application prompts the medical scheduler to prepare a Form ME023 appointment notification report for imaging into

¹³ *Id.* at Chapter 3.500.4.b(6)(a).

¹⁴ *Id.* at Chapter 3.500.5.

¹⁵ *Id.* at Chapter 3.500.5.a.

¹⁶ *Id.* at Chapter 3.500.4.f.

¹⁷ *Id.* at Chapter 3.500.4.f(1).

¹⁸ *Id.* at Chapter 3.500.4.f(1)(e)(2).

¹⁹ *Id.* at Chapter 3.500.4(f)(1)(e)(3).

²⁰ *Id.* at Chapter 3.500.5.b.

²¹ *Id.* at Chapter 3.500.5.c.

²² *Id.* Upon entry of a bypass code, the MMA will present the next physician based on specialty and zip code.

the case file.²³ Once an appointment with a medical referee is scheduled the claimant and any authorized representative is to be notified.²⁴

ANALYSIS -- ISSUE 1

The Board finds that OWCP did not abuse its discretion in denying appellant's request to participate in the selection of the referee physician. As noted, a claimant may request to participate in the selection of the referee physician or may object to the physician selected under the MMA. In such instances, the he or she must provide valid reasons for any request or objection to the claims examiner.²⁵ The right of the claimant to participate in selecting the medical referee is not unqualified. He or she must provide a valid reason such as documented bias or documented unprofessional conduct by the selected physician.²⁶ Appellant's representative asserted that Dr. McCaskill demonstrated unprofessional conduct as documented by a 1992 public reprimand for failure to practice medicine in an acceptable manner by failing to provide adequate testing follow up and a fine of \$1,000.00 for failure to timely release medical records in August 2009. The facts in this case are similar to a Board decision in *Jewell F. Milby*.²⁷ In the *Milby* case the claimant submitted several documents from the Kentucky Board of Medical Licensure which indicated that in a February 20, 1992 order of probation, the Kentucky Board found that in prescribing a controversial pain medication, the physician in question "although by no means intentionally or through gross negligence," had "deviated slightly from the standard of practice required by the Kentucky Medical Practice Act." In *Milby* the Board found that, as here, the record contained no evidence that the physician had been suspended from medical practice and determined that the physician had been properly selected as an impartial medical specialist.²⁸ The Board concludes that in the case at hand, as in *Milby*, the evidence of claimed unprofessional conduct by Dr. McCaskill does not rise to the level contemplated by OWCP's procedures described above.

The Board also finds that Dr. McCaskill was properly selected to perform the impartial evaluation. The record indicates that OWCP followed the procedures established by the MMA in selecting Dr. McCaskill. Appellant specifically questioned the validity of bypassing Dr. Woody, based on code L or location, and Drs. Hood, Holladay, McKeever, and Steele, based on code C or conflict. The record includes a screen shot and Form ME023 indicating that the Dr. McCaskill was selected. Attached was a log of bypassed physicians, including bypass codes and explanations of why each physician was bypassed, and a certification that the MMA had been used to select the referee physician. The bypass log indicated that Dr. Woody no longer travelled to the location listed. In e-mail correspondence dated December 2, 2013 and March 14,

²³ *Id.* at Chapter 3.500.5.g.

²⁴ *Id.* at Chapter 3.500.4.d.

²⁵ *Id.* at Chapter 3.500.4.f.

²⁶ *Id.* at Chapter 3.500.4.f(1).

²⁷ Docket No. 01-1763 (issued April 24, 2002).

²⁸ *Id.*; see also *P.M.*, Docket No. 11-2132 (issued August 2, 2012).

2014, OWCP explained that Drs. Hood and Holladay were in association with Dr. Mauldin (the second opinion physician) in a medical group called MCHC, formerly called OHS, and that Drs. McKeever and Steele were in a network called Churchill, in association with Dr. Tracy Adams who had previously seen appellant as a treating physician.

As noted by the Board in the case *Ronald Santos*,²⁹ a physician serving as an impartial medical specialist should be one who is wholly free to make a completely independent evaluation and judgment, untrammelled by a conclusion rendered on a prior examination.³⁰ An opinion of an associate of a physician who has previously rendered an opinion on the claim cannot be considered completely independent and therefore his report cannot be used by OWCP to resolve the conflict in the medical evidence.³¹ The importance of safeguarding the independence of impartial medical specialists is also recognized in OWCP procedures which indicate that it will select a physician who is qualified in the appropriate specialty and who has had no prior connection with the case or is an associate of another physician previously connected with the case.³²

While it is unclear in this case to what degree the members of the medical management groups MCHC and Churchill are associated, appellant has provided no evidence to support his proposition that these groups are merely schedulers. The Board finds that OWCP provided adequate documentation to establish that it properly utilized its MMA system in selecting Dr. McCaskill.³³

LEGAL PRECEDENT -- ISSUE 2

Causal relationship is a medical issue, and the medical evidence required to establish a causal relationship is rationalized medical evidence.³⁴ The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.³⁵ Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.³⁶

²⁹ 53 ECAB 742 (2002).

³⁰ *Id.*; see also *Raymond E. Heathcock*, 32 ECAB 2004 (1981).

³¹ *Id.*

³² *Supra* note 10 at Chapter 3.500.4.b.

³³ See *B.H.*, Docket No. 14-423 (issued June 26, 2014).

³⁴ *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

³⁵ *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

³⁶ *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

Once the primary injury is causally connected with the employment, Larson notes that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury.³⁷

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.³⁸ The implementing regulations of that section further provide that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination, and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.³⁹ When there exist 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 upon a proper factual background, must be given special weight.⁴⁰

ANALYSIS -- ISSUE 2

The Board finds that appellant has not met her burden of proof to establish lumbar radiculopathy was caused or aggravated by or was a consequence of the March 9, 2004 employment injury. In July 2013, OWCP determined that a conflict in medical opinion had been created between the opinions of Dr. Shah, an attending physician, and Dr. Mauldin, an OWCP referral physician, regarding the accepted ankle condition should be expanded to include a lumbar spine condition a consequential injury due to the March 9, 2004 injury. On July 17, 2013 it referred her to Dr. McCaskill for an impartial evaluation.

The Board finds that Dr. McCaskill's opinion is sufficiently rationalized to merit the special weight of a referee medical examiner.⁴¹ In a comprehensive report dated August 27, 2013, Dr. McCaskill noted appellant's complaints of significant back pain with minimum touch and her report that the back pain began spontaneously seven years after the March 2004 employment injury. Seated straight leg raising caused no obvious discomfort, and other than a decreased right infrapatellar reflex, there were no significant objective abnormal physical findings. Dr. McCaskill reported Dr. Perry's electrodiagnostic test findings of no electrophysiologic evidence of lumbosacral radiculopathy. He concluded that appellant had no credible objective residuals that could reasonably be attributed to the March 9, 2004 work injury. In regard to lumbar radiculitis, Dr. McCaskill indicated that, because he found no credible evidence of a significant ongoing left leg injury or any evidence of an injury to explain the persistence and magnitude of her back complaints, he found no basis to attribute the lower back

³⁷ Larson, *The Law of Workers' Compensation* § 1300; see Charles W. Downey, 54 ECAB 421 (2003).

³⁸ See *supra* note 6.

³⁹ See *supra* note 7.

⁴⁰ V.G., 59 ECAB 635 (2008).

⁴¹ *Id.*

and right leg complaints to the March 9, 2004 work injury and there was no credible evidence that the accepted left leg conditions would prevent her from returning to her regular work. He completed a work capacity evaluation on September 28, 2013 in which he indicated that appellant could perform her usual job for eight hours daily without restriction.

The additional medical evidence subsequently submitted is insufficient to overcome the weight accorded Dr. McCaskill as impartial medical specialist regarding the issue of whether appellant had a consequential lumbar condition. While Dr. Fritz indicated in a July 24, 2013 report that she had a chronic work-related foot injury, which altered her gait and affected her lumbar spine, he did not provide a reasoned explanation as to how the March 9, 2004 employment injury caused a low back condition. Without a detailed medical report describing the employment incident in detail and noting, physiologically, how and why appellant sustained a lumbar condition as a result of the March 9, 2004 employment injury, Dr. Fritz' opinion is not sufficient to meet appellant's burden of proof.⁴² Appellant also submitted a January 16, 2014 MRI scan study of the left foot, not relevant to the issue of whether she had a lumbar condition.

The Board therefore concludes that Dr. McCaskill's opinion that appellant did not have a lumbar condition causally related to the March 9, 2004 employment injury is entitled to the special weight accorded an impartial medical examiner.⁴³ The additional medical evidence submitted is insufficient to overcome the weight accorded him as an impartial medical specialist regarding this issue. Appellant therefore did not meet her burden of proof to establish that the claimed lumbar radiculopathy was causally related to the March 9, 2004 employment injury.

LEGAL PRECEDENT -- ISSUE 3

Once OWCP accepts a claim and pays compensation, it has the burden of justifying modification or termination of an employee's benefits. It may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.⁴⁴ OWCP's burden of proof to terminate compensation includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.⁴⁵

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 a claimant no longer has residuals of an employment-related condition that require further medical treatment.⁴⁶

⁴² See *M.L.*, Docket No. 14-1128 (issued September 17, 2014).

⁴³ See *Sharyn D. Bannick*, 54 ECAB 537 (2003).

⁴⁴ *Jaja K. Asaramo*, 55 ECAB 200 (2004).

⁴⁵ *Id.*

⁴⁶ *T.P.*, 58 ECAB 524 (2007).

ANALYSIS -- ISSUE 3

The Board finds that OWCP met its burden of proof to terminate appellant's wage-loss compensation and medical benefits effective January 13, 2014. The Board initially notes that Dr. McCaskill was not an impartial examiner on the issue of termination and his opinion therefore is not entitled to the special weight of a referee. Nonetheless, the Board finds that the weight of the medical evidence, based on the opinions of Dr. Mauldin and Dr. McCaskill, establishes that appellant had no continuing employment-related residuals.

In his April 23, 2013 report, Dr. Mauldin provided extensive examination findings, noting no evidence of skin discoloration or edema and normal distracted passive range of motion of the left lower extremity. He indicated that there were no objective findings of any significant left foot structural injury or to support her pain complaints. He recommended a FCE that was done on April 29, 2013 and indicated that appellant was self-limiting with numerous activities. On May 14, 2013 Dr. Mauldin advised that he had reviewed FCE and concluded that, based on his examination and FCE results, she could return to full duty.

On August 27, 2013 Dr. McCaskill also provided extensive physical examination findings. The only abnormal finding was a decreased right infrapatellar reflex, and the accepted conditions were of the left leg. With regard to the left lower extremity condition, Dr. McCaskill advised that appellant had apparent multiple nonphysiologic findings and no credible objective residuals attributed to the March 9, 2004 employment injury. He concluded that she could return to her usual job without restriction.

Dr. Shah, an attending physiatrist, indicated on January 29, 2013 that appellant complained of severe left foot pain and weakness and that examination demonstrated significant weakness with dorsal and plantar flexion and sensory loss along the peroneal distribution. On July 24, 2013 Dr. Fritz reported similar findings. The record, however, includes a September 26, 2013 electrodiagnostic study demonstrating normal bilateral peroneal motor and sensory nerve conduction, normal bilateral tibial conduction and no evidence of lumbosacral radiculopathy or plexopathy of the left lower extremity. A January 16, 2014 MRI scan study of the left foot merely demonstrated small synovial/ganglion cyst. Based on these negative objective studies, the Board finds the opinions of Dr. Shah and Dr. Fritz of diminished probative value regarding findings or weakness in dorsiflexion and plantar flexion and sensory loss along the peroneal distribution and concludes that the weight of the medical evidence rests with the opinions of Drs. Mauldin and McCaskill.

The weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.⁴⁷ The Board finds that the weight of the medical evidence regarding whether appellant continued to have residuals of the accepted conditions on or after January 13, 2014 rests with the opinions of Dr. Mauldin and Dr. McCaskill who provided reasoned explanations in their reports dated April 23 and August 27, 2013. Thus, OWCP met its

⁴⁷ *C.B.*, Docket No. 08-1583 (issued December 9, 2008).

burden of proof in finding that the March 9, 2004 employment injury resolved on January 13, 2014 and properly terminated appellant's wage-loss compensation and medical benefits.

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.

CONCLUSION

The Board finds that OWCP properly selected the impartial medical specialist, that appellant failed to meet her burden of proof to establish that her lumbar condition was a consequence of a March 9, 2004 employment injury, and that OWCP met its burden of proof to terminate her compensation benefits effective January 13, 2014.

ORDER

IT IS HEREBY ORDERED THAT the April 14 and January 9, 2014 decisions of the Office of Workers' Compensation Programs are affirmed.⁴⁸

Issued: December 2, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

⁴⁸ James A. Haynes, Alternate Judge, participated in the original decision but was no longer a member of the Board effective November 16, 2015.