



disease. Counsel restated that the impartial medical examiner did not base his opinion on the statement of accepted facts and that this report was therefore not of sufficient weight to resolve the conflict. He alleged that the impartial medical examiner lied and should be disqualified to offer opinions before OWCP. Counsel reviewed the medical evidence and argued in the alternative that the impartial medical examiner created an additional conflict of medical evidence.

### **FACTUAL HISTORY**

On April 9, 2011 appellant, then a 43-year-old letter carrier, filed a traumatic injury claim alleging that he stepped awkwardly down on a step with his right foot and twisted his right knee on that date. Dr. David E. Reinhardt, an osteopath, examined appellant on April 12, 2011 and noted that he twisted his right knee walking down some steps. He diagnosed right knee strain and sprain as well as probable meniscus tear. OWCP accepted appellant's claim for tear of the medial meniscus and sprain of the right knee on May 4, 2011. Appellant underwent a magnetic resonance imaging (MRI) scan on April 20, 2011 which demonstrated truncated posterior horn and body of the medial meniscus and mild cartilage loss at the medial femorotibial compartment. On May 19, 2011 he underwent a right knee arthroscopy with synovectomy, chondroplasty, and partial medial meniscectomy.

Appellant filed a notice of recurrence of disability on July 15, 2011 and stated on July 13, 2011 he was engaged in rehabilitation of his right knee and was attempting leg raises. His leg became unresponsive and would not lift. Dr. Reinhardt noted that appellant experienced back pain during physical therapy. He stated that appellant had back issues from an old work injury. On July 13, 2011 Dr. Reinhardt stated that appellant was experiencing worsening low back pain, weakness in his right thigh, giving way, and problems going up and down steps. He stated, "this all started after an incident that occurred in physical therapy on June 30<sup>th</sup>. [Appellant] was doing straight leg raising exercises and then was unable to perform them." In a statement dated July 13, 2011, appellant stated on June 27, 2011 he was attending physical therapy and performing leg raises when his leg became unresponsive and he could not raise it at all.

On August 8, 2011 OWCP accepted that appellant sustained recurrence of his previous back condition of lumbar sprain as a consequence of his right knee injury. It accepted aggravation of lumbar sprain on August 8, 2011 and degeneration of lumbar or lumbosacral disc.

Appellant underwent an MRI scan of the lumbar spine on July 15, 2011 which demonstrated progressive degenerative disc disease since October 21, 2004. He had bulging discs from L2-5 with a central disc protrusion at L5-S1. On July 29 and August 12, 2011 Dr. Reinhardt diagnosed exacerbation of the lower back condition with right lower extremity radiculopathy and weakness. In a note dated September 9, 2011, he diagnosed aggravation of the lower back condition with right lower extremity weakness, radiculopathy, and status post right knee arthroscopy.

Dr. Douglas C. Sutton, a Board-certified orthopedic surgeon, examined appellant on September 21, 2011 and diagnosed degenerative disc disease and degenerative joint disease, lumbar spine, as well as lumbar radiculopathy. He noted that appellant was undergoing

rehabilitation for his right knee when he aggravated his back. Dr. Sutton recommended conservative treatment.

Dr. Reinhardt examined appellant on September 27, 2011 and diagnosed medial right knee pain secondary to pes anserinus bursitis and right lower extremity weakness secondary to lumbar radiculopathy.

OWCP entered appellant on the periodic rolls on November 8, 2011. On January 24, 2012 Dr. Leonard A. Bruno, a Board-certified neurosurgeon, stated that appellant's low back pain had improved and that he had no leg pain. Appellant continued to experience right knee soreness.

Dr. Reinhardt examined appellant on February 7, 2012 and diagnosed chondritis, medial femoral condyle right knee, lumbar radiculopathy L5-S1 on the right and exacerbation and aggravation of low back pain, and degenerative disc disease lumbar spine. Appellant underwent a March 5, 2012 MRI scan, which demonstrated a partial tear of the medial collateral ligament. On April 17, 2012 Dr. Reinhardt diagnosed medial compartment osteochondral defects and chondritis as well as persistent chronic medial knee pain.

Dr. Bruno examined appellant on April 26, 2012 and noted that appellant reported only mild low back pain with no leg symptoms. He stated, "My impression is that the low back is basically okay."

OWCP referred appellant for a second opinion evaluation on May 14, 2012 with Dr. Steven J. Valentino, an osteopath. The accompanying statement of accepted facts listed the accepted conditions as medial meniscus tear and right knee sprain. Appellant's consequential back injury was not included. In a report dated June 5, 2012, Dr. Valentino noted appellant's history of injury and medical treatment for his knee and back. He found that appellant's lumbar spine examination was normal except for mildly restricted lumbosacral flexibility. Dr. Valentino noted that appellant's right knee showed mild synovitis and effusion. He diagnosed strain and sprain, torn medial meniscus right knee. Dr. Valentino noted that appellant's back was aggravated during physical therapy, but that his current back examination was normal and that the aggravation had ceased. He concluded that appellant continued to experience residuals of his right knee injury and required further treatment. Dr. Valentino stated that appellant was capable of limited-duty work.

Dr. Bruno examined appellant on September 10, 2012 due to his back condition. He found positive straight leg raising on the right with decreased sensation in the left L5 dermatome. Dr. Bruno stated that appellant had experienced some increase in his low back pain.

In a letter dated January 29, 2013, OWCP stated that appellant's claim was accepted for temporary aggravation of lumbar degenerative disc disease, resolved. The other accepted conditions included tear of the medial meniscus of the right knee and right knee strain.

In a report dated January 28, 2013, Dr. Bruno found that appellant had low back pain with straight leg raising on the left. He diagnosed facet sprain. Dr. Reinhardt examined appellant on February 11, 2013 and stated that he disagreed with OWCP's finding that appellant's aggravation of the lumbar spine had resolved. He diagnosed aggravation of lumbar

disc disease and torn medial meniscus and right knee strain with progressive degenerative joint disease and right knee.

Dr. Bruno examined appellant on March 1, 2013 and stated that he had undergone a series of facet block injections, which resulted in an essential resolution of his low back pain. He recommended that appellant have similar injections on an as needed basis. On May 20, 2013 Dr. Bruno stated that appellant reported his low back was sore due to the wet weather. Appellant did not report any leg pain or other symptoms. Dr. Bruno found that appellant had good response to lumbar facet blocks.

OWCP referred appellant for an additional second opinion evaluation with Dr. Robert Allen Smith, a Board-certified orthopedic surgeon on May 9, 2013. The accompanying statement of accepted facts did not mention appellant's accepted back condition. In a report dated May 30, 2012, Dr. Smith noted that appellant stepped awkwardly down a step with his right foot and twisted his right knee. He described appellant's consequential back injury and noted that he was not currently receiving treatment or medication for this condition. Dr. Smith performed a physical examination and reported that appellant had no spasm, atrophy, trigger points, or deformity in the spine with satisfactory motion. He stated that appellant's neurologic examination was objectively normal without focal motor or reflex deficit or atrophy. Dr. Smith stated that appellant's knee had no swelling or deformity with essentially full range of motion without crepitation, instability, or sign of internal derangement. He also found that appellant's motor strength was satisfactory. Dr. Smith concluded that appellant's medical meniscal tear and right knee sprain had resolved through surgery and physical therapy respectively. He stated:

“With regard to his back, it appears that OWCP accepted a temporary aggravation of his lumbar degenerative disc disease. However, according to the statement of accepted facts, this condition had resolved. Therefore, there does not appear to be any condition associated with the April 9, 2011 incident that is still active or has any residual.”

Dr. Smith opined that appellant's right knee arthritis was not an accepted condition and that his lumbar condition was preexisting and related to his 2004 employment injury. He found that appellant could return to regular-duty work as his current complaints were related to preexisting degenerative disease.

OWCP proposed to terminate appellant's wage-loss compensation and medical benefits by letter dated August 6, 2013. It relied on Dr. Valentino's report dated June 5, 2012, which it interpreted as stating that he found that appellant had sustained a temporary aggravation of his preexisting back condition which ceased by the time of his examination. OWCP further found that appellant had continuing residuals and restrictions as a result of his right knee condition which had resolved by May 30, 2013, the date of Dr. Smith's second opinion examination. It found that appellant was capable of returning to full duty.

Appellant submitted a letter disagreeing with the proposed termination and referenced a new report from Dr. Reinhardt. In a report dated August 16, 2013, Dr. Reinhardt described appellant's history of knee and back injury. He stated that on February 11, 2013 appellant reported continuing low back and medial knee pain. Dr. Reinhardt examined appellant on

June 25, 2013 and found that he could work four hours a day with restrictions on intermittent standing, sitting, and walking. He stated that appellant could drive a postal van and needed a mail cart. Dr. Reinhardt diagnosed low back facet joint pain, lumbar radiculopathy, chondritis medial femoral condyle, and tibial plateau, post-traumatic. He stated that appellant has ongoing continued objective evidence of pain on the medial side of his knee, weakness, loss of range of motion and back pain, with occasional gait dysfunction, and multiple trigger points in his back. Dr. Reinhardt stated that appellant could not return to full duty and that he required periodic orthopedic evaluation of his knee and back as well as medications. He opined that appellant's conditions were related to his April 4, 2011 employment injury and the aggravation of his lower back condition as the result of physical therapy for his right knee.

OWCP found a conflict of medical opinion evidence between Dr. Reinhardt and Dr. Smith regarding whether appellant was capable of performing full-duty work. It formulated a statement of accepted facts dated October 3, 2013. This statement of accepted facts indicated that appellant stepped awkwardly down on a step on April 9, 2011 and twisted his right knee. OWCP stated that the claim was accepted for medical meniscus tear on the right and right knee sprain. It noted that appellant discontinued physical therapy on June 30, 2011 due to complaints of increased back pain. The statement of accepted facts stated that OWCP accepted a temporary aggravation of lumbar degenerative disc disease resolved on January 20, 2013. OWCP referred appellant for an impartial medical examination with Dr. Barry Snyder, a Board-certified orthopedic surgeon.

Appellant returned to part-time work on October 10, 2013.

Dr. Snyder completed a report on February 3, 2014 and described appellant's April 9, 2011 incident as falling as his right knee gave out. He also noted that during physical therapy following knee surgery appellant developed back spasms. Dr. Snyder stated that appellant reported right knee pain and giving way, increased back pain with standing, and no radicular symptoms. He performed a physical examination and found identical range of motion in both knees, no crepitation, effusion, or laxity. Dr. Snyder noted that both knees had six degrees of valgus. Appellant's lower back examination demonstrated normal muscle strength in all lower extremities, normal light touch, and normal deep tendon reflexes. Dr. Snyder diagnosed medial meniscus tear, posterior horn, right knee, possibly aggravated by the April 9, 2011 injury at work, preexisting osteochondral defect possibly aggravated by the April 9, 2011 injury, preexisting chronic degenerative disc disease and degenerative arthritis, lumbar spine, neither caused nor aggravated by the April 9, 2011 injury and no objective evidence of permanent orthopedic, or peripheral neurologic impairment relating to the April 9, 2011 injury.

Dr. Snyder opined that appellant's right knee complaints after the April 9, 2011 employment injury were consistent with an element of superimposed injury from a fall onto preexisting degenerative joint disease with articular loss and associated meniscal changes present before April 9, 2011. He found that appellant's right knee MRI scan demonstrated patella alta, an anatomic abnormality predisposition to patellofemoral instability and associated articular changes. Dr. Snyder stated:

“[Appellant's] description to me was that his knee gave out and he fell -- not that an injury, such as a fall, caused his knee to give out. Such a history is more

indicative of a preexisting condition, such as patella alta with associated patellofemoral instability that became clinically manifest during his work, just as it might have done on any other occasion outside of work.”

He further opined that appellant’s meniscal tear was possibly aggravated by the April 9, 2011 employment injury. Dr. Snyder stated that appellant’s chondromalacia patella and unstable osteochondral flaps were articular abnormalities reflecting the extent of chronic degenerative changes of his right knee that were not related to his employment injury. He stated that appellant’s knee was relatively unremarkable with postoperative scarring, degenerative arthritic changes, and right knee pain on palpation. Dr. Snyder concluded that appellant’s right knee gave out while at work because of instability associated with preexisting developmental changes of the knee that were present before the incident. He stated, “Should it be administratively determined that the meniscal tear somehow related to the incident, [appellant] fully recovered in less than six weeks after arthroscopic surgery.”

Dr. Snyder found that appellant’s back condition was preexisting and that he had long standing degenerative disease which was not caused or structurally altered by his work incident or physical therapy. He stated that appellant had no objective evidence of neurologic impairment and disagreed with Dr. Bruno’s finding of facet joint sprain. Dr. Snyder stated, “Any current limitations relate to preexisting degenerative disease, independent of the April 9, 2011 incident.” He concluded that appellant could return to full duty with no restrictions.

In a decision dated February 26, 2014, OWCP terminated appellant’s medical benefits and wage-loss compensation effective February 27, 2014. It found that Dr. Snyder’s report was entitled to the weight of the medical opinion evidence and established that appellant’s knee and back conditions and limitations were not due to his employment.

Appellant requested an oral hearing from OWCP’s Branch of Hearings and Review on March 7, 2014.

In a note dated April 29, 2014, Dr. Bruno stated that appellant reported central to right low back pain. He stated that appellant’s condition was stabilizing and recommended that he return on an as-needed basis.

Counsel submitted argument on September 11, 2014 and asserted that the accepted conditions were never properly determined. He stated that there was a conflict of medical opinion evidence regarding whether appellant sustained an aggravation of preexisting degenerative disc disease. Counsel also argued that Dr. Snyder’s report was not based on the statement of accepted facts and therefore lacked an accurate history of injury and probative value.

Counsel appeared at the oral hearing on September 12, 2014 before the hearing representative, and presented the arguments also listed on appeal including that OWCP failed to accept the appropriate conditions as resulting from appellant’s April 9, 2011 employment injury and failed to properly adjudicate appellant’s claim for aggravation of his preexisting degenerative disc disease. Counsel stated that the impartial medical examiner did not base his opinion on the statement of accepted facts and that this report was therefore not of sufficient

weight to resolve the conflict. He alleged that the impartial medical examiner lied and should be disqualified to offer opinions before OWCP. Appellant testified and stated that his knee did not just give out as stated by Dr. Snyder, but that he stepped down on stairs and twisted his knee.

By decision dated November 3, 2014, another OWCP hearing representative, found that Dr. Snyder's report was entitled to the weight of the medical opinion evidence and established that appellant no longer had residuals of or disability due to his accepted April 9, 2011 employment injury.

### **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.<sup>2</sup> 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.<sup>3</sup> Furthermore, the right to medical benefits for an accepted condition is not limited to the period of entitlement for disability.<sup>4</sup> 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.<sup>5</sup>

When there are opposing reports of virtually equal weight and rationale, the case will be referred to an impartial medical specialist pursuant to section 8123(a) of FECA which 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 and resolve the conflict of medical evidence.<sup>6</sup> 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.<sup>7</sup> The opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.<sup>8</sup>

### **ANALYSIS**

The Board finds that OWCP failed to meet its burden of proof to terminate appellant's wage-loss compensation and medical benefits effective February 27, 2014.

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<sup>2</sup> *Mohamed Yunis*, 42 ECAB 325, 334 (1991).

<sup>3</sup> *Id.*

<sup>4</sup> *Furman G. Peake*, 41 ECAB 361, 364 (1990).

<sup>5</sup> *Id.*

<sup>6</sup> 5 U.S.C. §§ 8101-8193, 8123; *M.S.*, 58 ECAB 328 (2007); *B.C.*, 58 ECAB 111 (2006).

<sup>7</sup> *R.C.*, 58 ECAB 238 (2006).

<sup>8</sup> *Nathan L. Harrell*, 41 ECAB 401, 407 (1990).

OWCP referred a statement of accepted facts, a list of specific questions, and appellant to Dr. Snyder for an impartial medical opinion to resolve the conflict of medical opinion evidence regarding appellant's continuing disability as a result of his accepted employment injuries. This statement of accepted facts indicated that appellant stepped awkwardly down on a step on April 9, 2011 and twisted his right knee. OWCP stated that the claim was accepted for medial meniscus tear on the right and right knee sprain. It noted that appellant discontinued physical therapy on June 30, 2011 due to complaints of increased back pain. The statement of accepted facts further stated that OWCP accepted a temporary aggravation of lumbar degenerative disc disease resolved on January 20, 2013.

Dr. Snyder did not rely on the statement of accepted facts in formulating his opinion. He concluded that appellant's accepted employment injury of April 9, 2011 was not the cause of his accepted meniscal injury and attributed right knee injury to a preexisting condition. Dr. Snyder also listed a different description of appellant's employment incident stating that his right knee gave way, rather than was twisted. This description was disputed by appellant at the oral hearing and is not consistent with the remainder of the medical evidence, his statement on his claim form or the statement of accepted facts provided by OWCP. Dr. Snyder stated, "Should it be administratively determined that, the meniscal tear somehow related to the incident, [appellant] fully recovered in less than six weeks after arthroscopic surgery." He further opined that appellant did not sustain an aggravation of his preexisting back condition as accepted by OWCP.

In *Paul King*<sup>9</sup> the Board found that the report of an impartial medical examiner who disregarded a critical element of the statement of accepted facts was of diminished probative value. In *King*, the impartial medical examiner also disagreed with the medical basis for acceptance of a condition and indicated that if there was a previous determination by OWCP, only then would he consider any contribution to the claimant's condition. The Board found that this defective report was not sufficient to resolve the existing conflict of medical opinion evidence.

Dr. Snyder likewise disregarded the statement of accepted facts and, as in *King*, did not rely on the statement of accepted facts for the determination of the initial injury or the consequential injury. The Board finds that his report is of diminished probative value as his opinion disregarded critical elements of the statement of accepted facts and is therefore flawed. The Board notes that it is the function of medical expert to give an opinion only on medical questions, not to find facts.<sup>10</sup> Furthermore, to be given special weight, the opinion of an impartial medical specialist must be based on a proper factual background.<sup>11</sup> Dr. Snyder disregarded the statement of accepted facts in which OWCP described the employment incident and accepted medial meniscus tear on the right and right knee sprain as well as a consequential back injury. His report is not based on an accurate history of injury and is therefore not

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<sup>9</sup> 54 ECAB 356 (2003).

<sup>10</sup> *Id.*

<sup>11</sup> *R.M.*, Docket No. 12-496 (issued August 6, 2012).

sufficient to resolve the existing conflict of medical opinion evidence and meet OWCP's burden of proof to terminate appellant's wage-loss compensation and medical benefits.<sup>12</sup>

The Board finds that OWCP's decision terminating appellant's wage-loss compensation and medical benefits due to his accepted conditions of medial meniscus tear on the right and right knee sprain and temporary aggravation of lumbar degenerative disc disease is reversed as there is an unresolved conflict of medical opinion evidence. Due to the disposition of appellant's claim, it is not necessary for the Board to address the remainder of counsel's arguments on appeal.

**CONCLUSION**

The Board finds that OWCP failed to meet its burden of proof to terminate appellant's wage-loss compensation and medical benefits effective February 27, 2014

**ORDER**

**IT IS HEREBY ORDERED THAT** the November 3, 2014 decision of the Office of Workers' Compensation Programs is reversed.

Issued: May 22, 2015  
Washington, DC

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

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

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

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<sup>12</sup> *Id.*, see also *C.C.*, Docket No. 13-446 (issued May 15, 2013) (finding that the impartial medical examiner disagreed with an accepted condition and that his report was therefore of diminished probative value resulting in an unresolved conflict of medical opinion evidence and failure of OWCP to meet its burden of proof to terminate compensation benefits).