

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

E.C., Appellant)

and)

DEPARTMENT OF THE AIR FORCE,)
MAINTENANCE WORKING CAPITAL FUND,)
RANDOLPH AIR FORCE BASE, TX, Employer)

**Docket No. 15-1943
Issued: May 5, 2016**

Appearances:

*Jason S. Lomax, Esq., for the appellant
Office of Solicitor, for the Director*

Case Submitted on the Record

DECISION AND ORDER

Before:

COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 28, 2015 appellant, through counsel, filed a timely appeal from the April 13, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues on appeal are: (1) whether OWCP properly terminated appellant's medical benefits and wage-loss compensation effective February 3, 2014, as he was no longer disabled from work as a result of his work-related injury; and (2) whether appellant has met his burden of proof to establish continuing residuals or disability after the February 3, 2014 termination of his compensation benefits.

¹ 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On March 21, 2013 appellant then a 51-year-old letter carrier filed a recurrence claim (Form CA-2a) alleging that he sustained a flare up of his Achilles tendon in the performance of duty. He noted that it was not a new injury but only a flare-up. Appellant explained that his original injury was a broken ankle which healed. However, he advised that during rehabilitation, an injury to the Achilles tendon was discovered. Appellant indicated that he became aware of his disease or illness on March 12, 2013. He stopped work on March 12, 2013. OWCP developed this as a claim for a new occupational disease.²

In a February 19, 2013 report, Dr. Laura Ross, a Board-certified orthopedic surgeon and osteopath, noted that appellant had full range of motion in his right ankle, no swelling and some tenderness to palpation along the Achilles insertion on the right. She diagnosed a healed right ankle fracture and Achilles tendinitis. Dr. Ross advised that, after two weeks of physical therapy, appellant could return to full duty on March 5, 2013.

On March 25, 2013 appellant related an exacerbation of pain at the insertion of the Achilles tendon after his return to full duty. Dr. Ross explained that during the time appellant received physical therapy for the healed fracture, he developed Achilles tendinitis. She advised that the symptoms waxed and waned. Dr. Ross had returned appellant to full-time full-duty status on March 5, 2013 and was doing well; however, he had an exacerbation of Achilles tendinitis. She provided results on examination: full active range of motion of the right ankle; a negative Thompson's test bilaterally; and tenderness to palpation along the Achilles insertion on the right. Additionally, there was some swelling around the insertion of the right Achilles. Dr. Ross diagnosed a healed right ankle fracture and exacerbation of Achilles tendinitis. She recommended a walker boot and ordered a magnetic resonance imaging (MRI) scan of his right ankle. Dr. Ross placed him off work until the results of the MRI scan were made available.

In an April 1, 2013 report, Dr. Ross advised that since his last visit he had a right ankle MRI scan which was significant for Achilles tendinitis at the insertion site with no significant tear. She found range of motion of his right foot and ankle within normal limits. Dr. Ross found some point tenderness along the insertion of the right Achilles but no swelling. She diagnosed right Achilles tendinitis as a result from right ankle fracture and recommended a walker boot for four weeks and physical therapy. Dr. Ross placed appellant off work.

On May 14, 2013 OWCP accepted the claim for aggravation of right Achilles tendinitis. Appellant received wage-loss compensation and medical benefits.

Dr. Ross again saw appellant on May 20, 2013 and found tenderness to palpation over the Achilles insertion on the right and mild swelling at the Achilles insertion and range of motion of the right foot and ankle within normal limits. She advised that appellant had reached maximum medical improvement relative to the Achilles tendinitis. Dr. Ross explained that appellant's

² The record reflects that appellant had a prior claim accepted on September 11, 2012 for closed fracture of the distal fibula, right ankle. That claim was accepted under File No. xxxxxx554. Appellant returned to full duty on March 5, 2013. This claim has been combined with the present claim, File No. xxxxxx776, which serves as the master claim.

condition would be chronic and that appellant could not return to his duties as a letter carrier as he would have times of exacerbation, especially when walking on uneven surfaces. She opined that he could perform sedentary-type work.

Dr. Ross referred appellant to Dr. Joseph Daniel, a Board-certified orthopedic surgeon, to review the history of injury and treatment. In a June 26, 2013 report, Dr. Daniel reviewed diagnostic x-ray and MRI scan findings of the right ankle and noted that the right ankle fracture was completely healed. He found evidence of osteophytes about the anterior aspect of the distal tibia and the neck of the talus and evidence of a large enthesophyte at the insertion of the Achilles tendon. Appellant had normal range of motion of the ankles in dorsiflexion and plantar flexion. Dr. Daniel found passive dorsiflexion of the ankle on the right which was limited to 15 degrees and on the left to 30 degrees and passive plantar flexion of the ankles to 40 degrees. He explained there was no evidence of instability to anterior drawer testing in all positions and passive range of motion of the subtalar, talonavicular, calcaneocuboid, and tarsometatarsal articulations bilaterally was normal, apparently painless and without crepitation. Dr. Daniel indicated that there was evidence of degenerative arthritis of the right ankle as well as a right Achilles insertional tendinosis. He stated that these conditions were “not related to the accepted right ankle fracture whatsoever.” Dr. Daniel opined that appellant reached maximum medical improvement. He stated that he would be happy to manage the right ankle pain and Achilles insertional discomfort “outside the realm of [w]orkers['] [c]ompensation.”

In a July 8, 2013 report, Dr. Ross again noted appellant’s history and provided results on examination. She found full active range of motion in both ankles with no gross instability present. Dr. Ross found tenderness in the anterior aspect of the right ankle, no swelling, and a negative Thompson test. She diagnosed right ankle pain, early degenerative joint disease of the right ankle and Achilles tendinitis. Dr. Ross indicated that appellant could return to work with restrictions but could not perform the duties of a letter carrier. She disagreed with Dr. Daniel and asserted that appellant’s Achilles tendinitis and right ankle pain were due to the work injury.

On November 8, 2013 OWCP referred appellant for a second opinion, along with a statement of accepted facts, a set of questions and the medical record to Dr. Stanley Askin, a Board-certified orthopedic surgeon, to determine whether appellant continued to have any work-related residuals and or restrictions.

In a November 22, 2013 report, Dr. Askin noted appellant’s history of injury and treatment and provided examination results. Appellant’s current complaints included right ankle stiffness and pain in the front and back of the right ankle that worsened with activity. Dr. Askin related that appellant had pain that limited his walking. Calf circumferences measured 43 centimeters on the right and 43.5 centimeters on the left. Dr. Askin determined the circumferences of his ankles just above the malleoli were 22 centimeters equally. He determined that range of motion of his ankles was equivalent, both 30 degrees of plantarflexion and 10 degrees of dorsiflexion and there were symmetrical findings for both feet, with no edema, redness or deformity, and normal skin wear patterns on the soles of both feet, which were normal. Dr. Askin explained that appellant reported tenderness at the medial and distal Achilles tendon, but he found no outward manifestation of bursal enlargement. He did not detect any instability of the ankles on gentle stress. Dr. Askin also did not detect any crepitus of either

ankle as he moved the ankles through range of motion and that appellant was able to rise on his heels and toes, limited somewhat on the right.

Dr. Askin reviewed a May 28, 2013 MRI scan of the right ankle and explained that MRI scans were not equivalent to x-rays with regard to showing bony healing. However, he noted that the MRI scan was descriptive of the right distal fibular fracture and appeared to be healed. Dr. Askin reviewed x-rays from 2012 and diagnosed a fracture of the right distal fibula and advised that the case had been accepted for aggravation of Achilles tendinitis. He found no objective evidence and opined that appellant did not suffer from any disabling residual of his accepted condition. He explained that the condition had resolved. Dr. Askin opined that appellant had reached maximum medical improvement and could return to work without restrictions.

On January 2, 2014 OWCP issued a proposed notice to terminate appellant's wage-loss compensation as the weight of the medical evidence, as demonstrated by the opinion of Dr. Askin, established that appellant no longer had residuals or disability from work as a result of the work injury. Appellant was given 30 days to submit additional evidence or argument.

In a letter dated January 17, 2014, appellant responded to the notice of proposed termination. He questioned Dr. Askin's examination and findings noting that the examination lasted five to seven minutes in which he was asked a few questions and his calf and ankle area were measured. Appellant noted that Dr. Askin asked him to move his ankle around and to rise on his toes. However, he did not believe that Dr. Askin considered the physical requirements of his job. For example, appellant noted that at the end of the day, he had terrible pain and swelling in his ankle. He noted that his physicians had treated him since the date of his injury and they suggested that performing the full duties of a letter carrier position would only cause his Achilles tendon to continue to worsen. Appellant explained that his physicians indicated that he could return to modified duties and noted that he had accepted a modified job assignment. He requested that he be allowed to work in a modified capacity and that his case not be terminated.

In a December 3, 2013 duty status report (Form CA-7), Dr. Ross indicated that appellant could return to work on February 3, 2014 with restrictions, to include walking of no more than one hour on a level surface.

OWCP received a January 15, 2014 report from Dr. Steven B. Cancell, a podiatrist, who noted appellant's history of a previous right ankle fracture in September 2012 which healed uneventfully. Dr. Cancell indicated that appellant presented with right Achilles tendinitis and right ankle pain. He noted that during physical therapy, appellant developed Achilles tendinitis on the right side and was treated with a controlled ankle movement (CAM) boot. Dr. Cancell examined appellant and found that his vascular status was intact, there was mild edema of the right ankle, and there was a palpable retrocalcaneal spur with pain at the distal Achilles tendon, which seemed "somewhat out of proportion for the amount of pressure applied." He identified some pain in the right ankle joint and range of motion without crepitus but found appellant somewhat limited in extension, with tenderness anterolaterally in the ankle joint. Dr. Cancell explained that, after an ankle fracture, post-traumatic arthritis was extremely likely and Achilles tendinitis was something that occurs due to gait change. He opined that this was consistent with his previous injury and he agreed with Dr. Ross' restrictions as appellant required some change

in his work activity. Dr. Cancell explained that appellant was not trying to stay out of work, but attempting to change his position at work so that he did not have ongoing pain. He concurred with Dr. Ross with regard to his disability.

OWCP also received nurse reports dated May 13 and July 8, 2013 and January 16, 2014.

In a February 4, 2014 decision, OWCP terminated appellant's wage-loss compensation and medical benefits effective February 3, 2014.

On January 20, 2015 counsel for appellant requested reconsideration. He submitted no new medical evidence but submitted a brief arguing Dr. Cancell's report was entitled to greater weight as he was a foot and ankle specialist, that OWCP had incorrectly read Dr. Cancell's report, and that a conflict should have been declared with a referral to an impartial medical examiner.³

By decision dated April 13, 2015, OWCP reviewed the merits of counsel's arguments but denied modification of the prior decision. It continued to find that the weight of the medical evidence was represented by Dr. Askin.

LEGAL PRECEDENT -- ISSUE 1

Once OWCP accepts a claim and pays compensation, it bears the burden of proof to justify modification or termination of benefits.⁴ Having determined that an employee has a disability causally related to his or her federal employment, OWCP may not terminate compensation without establishing either that the disability has ceased or that it is no longer related to the employment.⁵

ANALYSIS -- ISSUE 1

In the instant case, OWCP accepted that appellant sustained aggravation of Achilles tendinitis, on the right.

OWCP developed the claim and referred appellant for a second opinion with Dr. Askin, who found that appellant could perform his job without restrictions. In a November 22, 2013 report, Dr. Askin reviewed appellant's history and examined him. Findings included symmetrical findings for both feet with no edema, redness or deformity, and normal skin wear patterns. Dr. Askin advised that, despite appellant's reports of tenderness at the medial and distal Achilles tendon, he found no outward manifestation of bursal enlargement and he did not detect any instability of the ankles on gentle stress. There was no crepitus of either ankle as he moved the ankles through range of motion. Dr. Askin reviewed diagnostic reports and noted that a May 28, 2013 MRI scan of the right ankle revealed the right distal fibular fracture appeared to be healed. He indicated that there were no objective findings or residuals of the accepted condition.

³ Counsel included a copy of Dr. Cancell's curriculum vitae from the doctor's website.

⁴ *Curtis Hall*, 45 ECAB 316 (1994).

⁵ *Jason C. Armstrong*, 40 ECAB 907 (1989).

Dr. Askin explained that appellant's subjective complaints did not correspond with any objective findings. He opined that appellant could return to work without restrictions.

The Board finds that Dr. Askin's opinion is entitled to the weight of the evidence as his report is rationalized and based upon a proper factual background. OWCP properly relied upon his reports in finding that appellant was no longer disabled from work. Dr. Askin did not attribute any current conditions to appellant's employment. He examined appellant, reviewed his medical records, and reported an accurate history.

Furthermore, the record contains medical evidence from one of appellant's physicians, Dr. Daniel, who supported that the work-related condition had resolved. On June 26, 2013 Dr. Daniel concluded that the right ankle fracture was completely healed and advised that there was evidence of degenerative arthritis of the right ankle as well as a right Achilles insertional tendinosis. He opined that these conditions were "not related to the accepted right ankle fracture whatsoever."

Reports from Dr. Ross, while supporting a continuing work-related condition, have limited probative value as they were devoid of medical rationale explaining her conclusions. There are no reports contemporaneous with the opinion of Dr. Askin which provide medical rationale explaining how any continuing residuals are employment related.⁶

In response to the notice of proposed termination, appellant submitted a January 15, 2014 report from Dr. Cancell. Dr. Cancell noted appellant's history of injury and treatment and examined him. His findings included that appellant had mild edema of the right ankle and a palpable retrocalcaneal spur with pain at the distal Achilles tendon, which seemed "somewhat out of proportion for the amount of pressure applied." Dr. Cancell found some pain in the right ankle joint, however, he noted that appellant's range of motion was without crepitus and somewhat limited in extension with tenderness anterolaterally in the ankle joint. He explained that post-traumatic arthritis was extremely likely after an ankle fracture and Achilles tendinitis was something that occurred due to gait change. Dr. Cancell advised that appellant was not trying to stay out of work, but attempting to change his position at work so that he did not have ongoing pain. He concurred with Dr. Ross with regard to disability. However, Dr. Cancell did not explain his opinion. This is important as he appears to attribute some of appellant's symptoms to post-traumatic arthritis, a condition not accepted as employment related,⁷ and found that some of appellant's responses were out of proportion. Without further rationale, this report is of limited probative value.

The Board finds that OWCP properly terminated appellant's medical benefits and wage-loss compensation effective February 3, 2014, as he was no longer disabled from work as a result of his work injury.

⁶ See *George Randolph Taylor*, 6 ECAB 986, 988 (1954) (where the Board found that a medical opinion not fortified by medical rationale is of little probative value)

⁷ Where an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish an employment relationship. See *Jaja K. Asaramo*, 55 ECAB 200 (2004).

LEGAL PRECEDENT -- ISSUE 2

It is well established that after termination or modification of compensation benefits, clearly warranted on the basis of the evidence, the burden for reinstating compensation shifts to appellant. In order to prevail, appellant must establish by the weight of the reliable, probative and substantial evidence that she had an employment-related disability, which continued after termination of compensation benefits.⁸

ANALYSIS -- ISSUE 2

Subsequent to the February 4, 2014 decision, which terminated appellant's compensation benefits effective February 3, 2014, the burden shifted to appellant to demonstrate that he continued to have disability for work on and after February 3, 2014 due to the accepted injury.⁹

After the termination of appellant's compensation benefits, OWCP received a January 20, 2015 request for reconsideration from counsel. He submitted a brief and a copy of Dr. Cancell's curriculum vitae. Counsel argued that Dr. Cancell's report was entitled to greater weight as he was a foot and ankle specialist, that OWCP had incorrectly read Dr. Cancell's report, and that a conflict should have been declared and a referral to an impartial medical examiner was warranted. The Board finds that these arguments do not support continuing injury-related residuals or disability after February 3, 2014. The issue in the present case is medical in nature and must be resolved by the submission of reliable, probative, and substantial evidence.¹⁰ Appellant's arguments are not sufficient to meet his burden of proof that appellant continued to suffer residuals from his accepted work-related condition after February 3, 2014. The Board finds Dr. Askin is sufficient to represent the weight of the medical evidence.

On appeal, counsel for appellant argues that Dr. Cancell was a foot and ankle specialist and his report was well rationalized and supported that appellant had residuals of his accepted conditions. He also argues that his opinion was entitled to greater weight and that in the alternative, a conflict was created. However, as found above, the weight of the evidence is attributed to Dr. Askin, who provided a rationalized report and supported that appellant was no longer disabled from work as a result of his work-related injury. As explained, the reports of Drs. Cancell and Ross are of limited probative value and insufficient to create a medical conflict.¹¹

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.

⁸ *Talmadge Miller*, 47 ECAB 673, 679 (1996); *Wentworth M. Murray*, 7 ECAB 570, 572 (1955).

⁹ *See id.*; *Virginia Davis-Banks*, 44 ECAB 389 (1993).

¹⁰ *Supra* note 6.

¹¹ *See* 5 U.S.C. § 8123(a). *See also John D. Jackson*, 55 ECAB 465 (2004) (a simple disagreement between two physicians does not, of itself, establish a conflict; to constitute a conflict of medical opinion, the opposing physicians' reports must be of virtually equal weight and rationale).

CONCLUSION

The Board finds that OWCP properly terminated appellant's medical benefits and wage-loss compensation effective February 3, 2014, as he was no longer disabled from work as a result of his work-related injury. The Board also finds that appellant has not met his burden of proof to establish continuing residuals or disability after the February 3, 2014 termination of his compensation benefits.

ORDER

IT IS HEREBY ORDERED THAT the April 13, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 5, 2016
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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