U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of JACQUELINE ACKERMAN and DEPARTMENT OF VETERANS AFFAIRS, J.L. PETTIS MEMORIAL HOSPITAL, Loma Linda, CA

Docket No. 00-2519; Submitted on the Record; Issued September 13, 2001

DECISION and ORDER

Before DAVID S. GERSON, BRADLEY T. KNOTT, PRISCILLA ANNE SCHWAB

The issue is whether appellant sustained a recurrence of disability.

The Office of Workers' Compensation Programs accepted that on March 5, 1996 appellant, then a 49-year-old medical clerk, sustained a right ankle contusion in the course of her employment.[1] Appellant was placed in a light-duty position in accordance with her restrictions on March 12, 1996.

In an April 3, 1996 report, Dr. William C. Hanes, a Board-certified orthopedic surgeon, noted that a cyst was removed from appellant's right ankle on December 21, 1995 and that she was kicked on the incision on March 5, 1996. Dr. Hanes noted that the incision was well healed, with slight soft tissue swelling in the periincisional area. He opined that appellant's neurovascular status was unremarkable for slight decrease and light touch just distal to the distal end of the incision. Dr. Hanes' diagnostic impression was that appellant had made satisfactory progress three and a half months postexcision of a benign ganglion cyst. He recommended that appellant continue her stretching exercises and continue the use of an ankle brace on an as needed basis.

In a May 3, 1996 report, Dr. Hanes indicated appellant returned for follow up of right ankle pain. He noted right ankle swelling and pain and indicated that she could continue full duty at work but keep an eye on the amount of standing and walking that she did, and to elevate the foot if swelling were to occur.

[1] Appellant had surgery to her ankle on December 21, 1995 and was kicked by a co-worker on March 5, 1996 while she was assisting a patient. Appellant has a previous claim, which the Office accepted for left lateral epicondylitis, as a result of the performance of her duties as a meat cutter. That claim was previously on appeal and the Board found that the Office did not meet its burden to terminate appellant's compensation benefits. The Board reversed the decision to terminate and indicated the Office should refer appellant for a psychiatric condition and authorize surgical treatment for appellant's condition. (Docket No. 95-583, issued January 16, 1997.)

In a June 6, 1996 disability certificate, Dr. Hanes stated that appellant had restrictions of no standing for more than four hours per shift and no standing greater than a half hour at a time.

In an April 8, 1997 letter, the employing establishment indicated that appellant was never removed from light duty. Additionally, it was possible that she would need surgery.

By letter dated June 30,1997, the Office advised appellant and her surgeon, that he should provide his reasoning, supported by medical rationale as to the relationship of appellant's prior injury, her current condition, and how both injuries related to the surgery request.

In an August 1, 1997 report, Dr. Herman R. Schoene, a Board-certified orthopedic surgeon, indicated that appellant had surgery for two prior excisions of a synovial type of cyst from her right ankle. Dr. Schoene stated that the first surgery was done in December 1994 and the second was done in December 1995. He noted that appellant was subsequently kicked in the ankle while at work in March 1996, aggravating the surgical site. Dr. Schoene indicated that appellant required a repeat excision of this cyst and that she would have developed this recurrence whether or not she had the injury at work. He noted that at most, the injury at work temporarily aggravated her ankle problem, however he indicated that this aggravation had since resolved without sequelae. Dr. Schoene further opined that any further treatment of the right ankle cyst should be provided under appellant's health plan.

On February 25, 1998 appellant filed a notice of recurrence of disability alleging that her ankle condition had persisted and that she had several surgeries since the incident. Appellant continued on light duty.

In a June 12, 1998 decision, the Office denied appellant's claim on the grounds that the evidence of record failed to establish a causal relationship between the original injury and her condition on or after February 25, 1998.

In a June 24, 1998 letter, which was faxed to the Office, appellant, through, a representative, requested reconsideration and submitted additional medical evidence.

In a March 25, 1998 report, Dr. David E. Smalley, a Board-certified orthopedic surgeon, indicated that appellant had previous right ankle surgery in 1994 and 1995 for lipoma removal. He diagnosed a right lateral malleolus bone cyst with possible pigmented villonodular synovitis; right anterior lateral ankle joint synovitis and effusion, and a history of previous lipoma excision, times 2, right anterior lateral ankle. Dr. Smalley opined that the cystic erosion was in a little more posterior position than he would expect to be from surgical changes and, therefore, synovitis appears to be the most likely cause of appellant's cystic erosion of the distal fibula. He further opined that it was his opinion that appellant likely had some synovitis previously which contributed to the formation of the "lipoma" and the injury on March 5, 1996 aggravated appellant's synovitis and contributed to a relatively aggressive treatment plan by her primary physician, as well as relatively aggressive amount of persisting synovitis. He also added that appellant's persisting activity level and recurrent fusion also contributed to her persisting difficulties and her present course. He indicated that some permanent residuals were expected and included but were not limited to bony changes in the distal fibula and residual swelling.

By letter dated June 29, 1998, the Office advised appellant that they were referring her for a second opinion and requested that she forward all of her medical reports.

In a November 4, 1998 report, Dr. Fredrick J. Lieb, a Board-certified orthopedic surgeon, noted appellant's history of injury and treatment. Dr. Lieb diagnosed: a cystic mass, anterolateral aspect of the right ankle, status postop excision, times two; a cystic mass that may constitute pigmented or nonpigmented nodular tenosynovitis; and a contusion to the right ankle, which was resolved. He indicted that appellant continued to suffer residuals of the injury of March 5, 1996. Dr. Lieb indicated that it was his opinion that appellant had two prior excisions of a mass, which she described as a lipoma at the lateral aspect of the right ankle. He stated that appellant was working at the time of the incident with no restrictions and following the incident, she remained on light duty. Dr. Lieb noted that appellant had swelling over the anterolateral aspect of the right ankle since that date. He indicated that he did not believe that anybody could make a specific diagnosis regarding the etiology of the cystic mass involving the right ankle and he could not determine whether these changes were the result of intrinsic or extrinsic factors. Dr. Lieb also indicated that the prior medical records from Kaiser Permanente were particularly important with regard to the mass that was previously excised. He stated that based on the information provided on this date, it was his opinion that the incident of March 5, 1996 permanently aggravated the preexisting condition. Dr. Lieb advised that another excisional biopsy of the masses needed to be obtained with respect to a thorough pathologic examination. He noted that the only disability appellant experienced since the incident was being placed on light duty. Additionally, Dr. Lieb indicated the industrial injury of March 5, 1996 permanently aggravated the preexisting mass excised from appellant's right ankle and noted that appellant be precluded from standing, walking or other weight bearing activities for more than 15 minutes at a time, and for a total of 2 hours throughout the working day. Appellant should also be precluded from activities that required squatting on a repetitive or prolonged basis.

By letter dated November 23, 1998, the Office advised appellant that they had previously requested that she provide copies of her Kaiser records for the second opinion examination. The Office advised appellant that her reconsideration request would be denied unless the information was submitted. Appellant was advised that she had 15 days to submit her entire medical file from Kaiser.

By letter dated December 3, 1999, appellant replied that she was initially informed that it was all right if she did not have them for her appointment with Dr. Lieb as she did not have enough time to obtain the records. She informed the Office that she was in the process of obtaining those records and requested reimbursement for the fees she would have to incur.

On December 14, 1998 the Office received 66 pages of clinical progress notes, physical therapy reports and treatment notes from Kaiser permanente.

In a December 27, 1994 bone scan of the right ankle, which was received by the Office on December 14, 1998, Dr. G.H. Pez, a radiologist, diagnosed a mass of the right ankle consistent with multilocular synovial-type cyst containing proteinaceous material.

In a December 28, 1994 operative report, which was received by the Office on December 14, 1998, Dr. Hanes indicated that a mass of the right ankle was excised. The findings were consistent with that of a large gangrenous cyst.

In a December 7, 1995 magnetic resonance imaging scan of the right ankle, which was received by the Office on December 14, 1998, Dr. Paul C. Doehring, a Board-certified diagnostic radiologist, noted findings most compatible with septic arthritis involving the tibio-talar and subtalar joints, with osteomyelitis involving the talus and calcaneus.

In a December 11, 1995 radionuclide skeletal scintigraphy report, which was received by the Office on December 14, 1998, Dr. Jace C. Low, a radiologist,[2] concluded that the findings suggested septic arthritis rather than osteomyelitits in the right ankle joint.

In a December 21, 1995 operative report, which was received by the Office on December 14, 1998, Dr. Hanes indicated that appellant had a recurrent mass of the right ankle. Dr. Hanes' postoperative diagnosis was that appellant had a probable recurrent ganglion cyst, right ankle joint and subtalar joint.

In a December 21, 1995 bone scan of the right ankle, which was received by the Office on December 14, 1998, Dr. Pez diagnosed a mass to the right ankle consistent with granulomatous synovitis, positive for mycobacteria by flurostain, and traumatic neuroma.

In a February 19, 1997 report, which was received by the Office on December 14, 1998, Dr. Schoene noted that appellant had excision of a synovial cyst from her right ankle twice, once in December 1994 and once in December 1995. Dr. Schoene indicated that, on both occasions, it was a synovial-type cyst. He noted that the second time, there was a discussion about a granulomatous cyst. Dr. Schoene indicated that appellant was kicked at work in the right ankle, which aggravated the cyst. He diagnosed a synovial-type cyst of the right ankle and recommended a reexcision of the cyst.

In a December 9, 1997 report, which was received by the Office on December 14, 1998, Dr. Hanna O. Sanders, Board-certified in physical medicine and rehabilitation, noted that appellant had surgery for the removal of lipoma from the lateral aspect of the right ankle. Dr. Sanders noted that appellant stated she was having a good recovery, returned to work in a light-duty capacity and on March 5,1996 was kicked in the right lateral ankle by a co-worker, which caused a severe breakdown in the healing surgical area. She stated that appellant was status post removal of the lipoma from lateral aspect of the ankle in December 1995 with subsequent trauma (contusion secondary to kicking) on March 5, 1996 on the job. Dr. Sanders noted that swelling and pain were secondary in the right ankle. She also noted that the ankle probably would need to be surgically addressed but she would initially like to try some conservative methods.

[2] Dr. Low was not listed in any of the certification directories, however, based upon the report, it appears that he is a radiologist.

By letter dated January 7, 1999, the Office advised appellant that she was being referred back to Dr. Lieb for clarification of his opinion regarding her ankle.

In a March 8, 1999 report, Dr. Lieb indicated that appellant's diagnosis was lateral epicondylitis of the left elbow and pigmented villonodular tenosynovitis of the right ankle. With respect to appellant's ankle, Dr. Lieb noted that in his initial evaluation, he did not have the medical records regarding the removal of what he thought was a lipoma. Upon receipt of the medical records, Dr. Lieb noted that on each occasion, a synovitis consistent with pigmented villonodular tenosynovitis was diagnosed. Dr. Lieb stated that the injury of March 5, 1996 constituted a temporary aggravation of her preexisting condition. He also stated that the pigmented villonodular tenosynovitis appeared to have involved not only the subcutaneous tissue adjacent to the lateral malleolus but also involved the ankle joint and the bony structure of the lateral malleolus and possibly, other bony structures in the area of the right foot and ankle. Dr. Lieb stated that it was his opinion that the contusion of the right ankle which occurred on March 6, 1996, constituted a temporary aggravation of her preexisting condition which has now had more than adequate time for full recovery. He also stated that appellant's complaints and findings referable to the right ankle were totally related to her preexisting nonindustrial pigmented villonodular tenosynovitis of the right ankle. Dr. Lieb noted that the condition's etiology was not completely understood, however, it appeared to be an inflammatory condition, and there was no significant evidence of a traumatic etiology associated with this condition. Additionally, with respect to the right ankle, Dr. Lieb indicated that appellant did have significant residuals but they were not work related, but rather a result of a preexisting, nonindustrial condition. Dr. Lieb explained his rationale for his opinion by indicating the pigmented villonodular tenosynovitis was an inflammatory condition without any evidence of traumatic etiology. He also opined that the diagnosis of pigmented villonodular tenosynovitis could not be made without surgical incision of the involved cystic masses and through pathologic study of the tissues removed. Dr. Lieb stated that in view of the evidence of involvement of the bony structures, this may be an incurable condition, short of amputation. He indicated that appellant could perform her job provided there was a permanent restriction of limiting weight bearing to 15 minutes or less, continuously, and that her work be carried out primarily in a sitting position. Dr. Lieb indicated that appellant was capable of performing a full-time, sedentary job.

By letter dated April 5, 1999, the Office requested clarification from Dr. Lieb.

In an April 14, 1999 report, Dr. Lieb indicated that this type of blunt trauma to a preexisting condition should generally heal and return to its previous state within three to four months. However, it was difficult to determine when the temporary aggravation ceased due to the preexisting condition, which continued to progress. Dr. Lieb indicated that he would accept Dr. Schoene's opinion that the aggravation ceased on August 1, 1997 because he was appellant's treating physician and followed her course of care for some time.

By merit decision dated April 26, 1999, the Office denied appellant's request for on the grounds that evidence submitted was insufficient to warrant modification.[3]

The Board finds that appellant has not established that she sustained a recurrence of disability.

When an employee, who is disabled from the job he or she held when injured on account of employment-related residuals, returns to a limited- or light-duty position or the medical evidence establishes that the employee can perform the light-duty position, the employee has the burden to establish by the weight of the reliable, probative and substantial evidence, a recurrence of total disability and to show that he or she cannot perform such light duty. As part of this burden, the employee must show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the light-duty job requirements.[4] Appellant must furnish rationalized medical opinion evidence, based on a complete and accurate factual and medical history, showing a causal relationship between the claimed recurrence of disability and an accepted employment injury.[5] Causal relation and disability are medical issues that must be resolved by competent medical evidence.[6]

Appellant has not provided any medical reports, based on objective findings, which establish that there has been a change in the nature and extent of her condition such that she can no longer perform her light-duty job and also has provided no evidence to establish that there has been a change in the nature and extent of her light-duty job requirements. On June 12, 1998, the Office denied appellant's claim on the grounds that evidence of record failed to establish a causal relationship between the original injury and her condition on or after February 25, 1998. The Office advised appellant of the type of medical and factual evidence needed to establish her claim for a recurrence of disability; however, appellant has not submitted such evidence.

In an April 3, 1996 report, Dr. Hanes indicated that appellant returned for follow up for the right ankle cyst that was removed from the right ankle on December 21, 1995. Dr. Hanes noted that appellant was kicked on the incision on March 5, 1996 and appellant had increased pain but no significant swelling or bruising. He also noted the incision was well healed, with soft tissue swelling in the peri-incisional area. Dr. Hanes indicated that appellant had made satisfactory progress three and a half months postexcision of a benign ganglion cyst. Additionally, in his May 3, 1996 report, Dr. Hanes indicated that appellant could continue full duty at work but should keep an eye on the amount of standing that she did and to elevate the foot if swelling were to occur. These reports did not indicate that appellant was disabled and were therefore insufficient to establish appellant's claim for recurrence of disability due to the

[3] The Office advised appellant that they had updated her claim to retroactively accept the condition of temporary aggravation of villonodular tenosynovitis, ceasing August 1, 1997. The Office advised appellant that, if she lost time due to this injury prior to August 1, 1997, she should fill out a CA-7 for lost time and that her medical bills prior to August 1, 1997 would also be paid.

[4] *Richard E. Konnen*, 47 ECAB 388 (1996); *Terry R. Hedman*, 38 ECAB 222, 227 (1986).

[5] *Armondo Colon,* 41 ECAB 563 (1990).

[6] *Debra Kirk-Littleton,* 41 ECAB 703 (1990); *Ausberto Guzman,* 25 ECAB 362 (1974).

March 5, 1996 injury. A subsequent report from Dr. Hanes dated June 6, 1996 placed appellant on restrictions again, but he did not indicate that appellant was disabled or unable to perform light duty. Additionally, Dr. Hanes did not explain why he indicated appellant could return to full duty in May and changed his restrictions one month later.

Appellant provided reports dated February 19, 1997 and August 1, 1997 from her treating physician, Dr. Schoene, who indicated that appellant had two prior surgeries for excision of a synovial type of cyst from her right ankle and that both of these surgeries predated the accepted employment incident of March 5, 1996. In his August 1, 1997 report, Dr. Schoene indicated that appellant required a repeat excision of this cyst and that she would have developed this recurrence whether or not she had the injury at work. He noted that at most the injury temporarily aggravated the ankle problem, but this had since resolved. Additionally, he did not state that she was unable to perform her light-duty position.

A December 9, 1997 report from Dr. Sanders indicated appellant had surgery for removal of a lipoma from the lateral aspect of the right ankle. This report was based on an inaccurate history as the reports from appellant's surgeon on both occasions indicate a synovial type of cyst was removed. This report was therefore inaccurate and therefore of limited probative value.[7]

Appellant provided a March 25, 1998 report from Dr. Smalley who indicated that appellant had previous right ankle surgery in 1994 and 1995 for lipoma removal. The record reflects that appellant's previous surgeries were for removal of a cyst. Dr. Smalley's report does not accurately reflect appellant's medical history and is of limited probative value.[8] Appellant has the burden to establish by the weight of the reliable, probative and substantial evidence, a recurrence of total disability and show that she cannot perform such light duty.[9]

Dr. Lieb, the second opinion physician, initially examined appellant on November 4, 1998 and was not provided with appellant's entire medical file. He initially stated that the March 5, 1996 incident permanently aggravated appellant's preexisting condition, as he believed she had a lipoma and recommended light-duty restrictions. However, after being supplied with the requested medical records, and discovering that appellant did not have a lipoma but a cyst, Dr. Lieb determined that appellant had pigmented villonodular tenosynovitis of the right ankle. He opined that the injury of March 5, 1996 was a temporary aggravation of her preexisting condition. Dr. Lieb stated that the pigmented villonodular tenosynovitis of the right ankle involved not only the subcutaneous tissue adjacent to the lateral malleolus but it also involved the ankle joint and the bony structure of the lateral malleolus and possibly, other bony structures in the area of the right foot and ankle. He further explained that the contusion of March 5, 1996

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[7] *See Vernon R. Stewart,* 5 ECAB 276, 280 (1953) (where the Board held that medical opinions based on histories that do not adequately reflect the basic facts are of limited probative value in establishing a claim); *see also Connie Johns,* 44 ECAB 560 (1993). The opinion of a physician supporting causal relationship must be one of reasonable medical certainty, supported with affirmative evidence, explained by medical rationale and based on a complete and accurate factual and medical background.

[8] *See* footnote 7.

[9] *See Richard E. Konnen, supra* note 4.

was a temporary aggravation of her preexisting condition, which had more than adequate time for full recovery. Dr. Lieb also explained that appellant's condition was an inflammatory condition, with no significant evidence of a traumatic etiology associated with this condition. He opined that, due to the involvement of the bony structures, this may be an incurable condition, short of amputation. Dr. Lieb also opined that appellant could perform her job provided there was a permanent restriction of lifting weight bearing to 15 minutes or less. In his April 14, 1999 report, Dr. Lieb explained that this type of blunt trauma to a preexisting condition should generally heal and return to its previous state within a three to four month time frame, however due to the preexisting condition which appeared to be progressive, he would accept Dr. Schoene's account of August 1, 1997 as the date the aggravation had ceased. This report is of limited probative value as it does not assist appellant in meeting her burden that she sustained a recurrence of total disability such that she could not perform light duty as he indicated that she could do some time of light-duty position.

Appellant also provided operative and diagnostic reports of her 1994 and 1995 surgeries, however, these predated the employment incident, and they were not relevant to establish that appellant was unable to perform her light-duty requirements or to establish a change in her condition.[10]

As appellant has not submitted competent medical evidence showing that she was disabled beginning February 25, 1998, due to her accepted employment injury, she has not met her burden of proof.[11]

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[10] These records were essential with respect to providing an accurate factual background in order to assess appellant's medical history.

[11] Following the issuance of the Office's April 26, 1999 decision, appellant submitted additional evidence. However, the Board may not consider such evidence for the first time on appeal.

The decision of the Office of Workers' Compensation Programs dated April 26, 1999 is hereby affirmed.

Dated, Washington, DC
September 13, 2001

David S. Gerson
Member

Bradley T. Knott
Alternate Member

Priscilla Anne Schwab
Alternate Member