U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ERNEST L. HARCROW and DEPARTMENT OF THE ARMY, ANNISTON ARMY DEPOT, Anniston, AL

Docket No. 01-280; Submitted on the Record;
Issued April 1, 2002

DECISION and ORDER

Before ALEC J. KOROMILAS, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issues are: (1) whether the Office of Workers' Compensation Programs met its burden of proof to terminate appellant's wage-loss compensation benefits, effective April 25, 1999; and (2) whether appellant met his burden of proof to establish that he is entitled to continuing compensation benefits on or after April 25, 1999.

On November 27, 1985 appellant, then a 38-year-old battery repairer, filed a traumatic injury claim stating that he got caught between a truck/forklift and tow motor while attempting to turn the generator off and fractured his right tibia and fibula in the course of his federal employment duties. The Office accepted that appellant sustained a compound fracture of the lower right leg. Appellant stopped work and did not return. The Office placed appellant on the periodic rolls and paid appropriate compensation benefits.

On February 20, 1997 appellant's treating physician, Dr. Richard D. Meyer, a Board-certified orthopedic surgeon, opined that appellant was back after a lengthy absence, with a case worker, to determine if he could go back to work, and if so, in what capacity. Dr. Meyer noted that appellant did not have the same pain as three years ago. He observed that appellant went from 0 to 120 with some mild varus and some degree of hyperextension of his knee. Dr. Meyer noted that the leg was still mildly short. He stated that he thought appellant could return to work at the battery shop without significant limitations, except for squatting. Dr. Meyer stated that he thought that appellant could return to work at continuous sitting, intermittent walking, lifting, bending, climbing, twisting and standing, but with no squatting and limited to less than an hour of kneeling a day. He indicated that appellant could not lift anything over 50 pounds and that he was at maximum medical improvement. Dr. Meyer stated that x-rays of the tibia showed that his fracture was very solid and there was only 10 to 15 degrees of recurvatum at the mid shaft and only in minimal varus.

In an October 23, 1997 report, Dr. Meyer indicated that appellant was seen as he had fallen off his porch in August and was seen in the emergency room. Appellant was being

examined for follow-up. Dr. Meyer noted that no interval change was observed from that of February, although appellant was complaining of some mild pain in the area. He opined that he did not feel that there was any intervention that would make any difference and he opined that his February 20, 1997 report was still accurate.

On November 3, 1998 the employing establishment provided the Office with a detailed description of the physical requirements of appellant's original position as a battery repairer. The position did not require squatting, kneeling or lifting over 50 pounds.

The Office issued a notice of proposed termination of compensation on February 22, 1999. Appellant was given 30 days to submit additional evidence from his physician if he disagreed with the proposed action.

By letter dated March 15, 1999, appellant advised that, since the date Dr. Meyer did his last evaluation, his leg had worsened. He stated that he had to start using a cane and during the evaluation, all the doctor did was talk to him and since he was 60 percent deaf, he may not have heard him right. Appellant stated that no testing was done on his leg. He stated further that the work restriction evaluation stated a number of things, which he could not do. Appellant enclosed an undated work restriction evaluation and progress notes from September 30, 1998. The progress notes do not appear to have been signed by a physician as no signature was apparent. These notes discussed appellant's chronic condition and his hearing.

In a February 25, 1999 radiology report, received by the Office on April 9, 1999, Dr. Robert R. Lopez, a Board-certified diagnostic radiologist, stated that there has been no significant interval change in a radiographically healed comminuted fracture of the proximal tibia as well as the transverse healed fracture of the mid-fibular shaft. A slight posterior fracture apex angulation of both bones was again noted.

By decision dated April 26, 1999, the Office terminated appellant's wage-loss compensation benefits effective April 25, 1999. The Office specifically advised that appellant continued to be entitled to medical treatment solely for the accepted work-related condition of compound fracture of the right lower leg.

In a report dated February 25, 1999 and received by the Office on April 26, 1999, Dr. Meyer noted that appellant returned with pain in the right proximal tibia. He noted that appellant was having pain in the left heel and was noted to be shorter on the right. Dr. Meyer observed that there was no significant tenderness in the right proximal leg and appellant would be started with Celebex to see if that made a difference. He stated that appellant measured about one-half inch shorter on the right leg and a prescription for a one-half inch heel lift would be made.

In a May 3, 1999 report, Dr. Meyer stated that appellant was complaining of pain in his tibia fracture in the area of the break. He noted that there was no drainage, no real tenderness and appellant's x-rays looked good. Dr. Meyer also observed that appellant was wearing a brace, which appellant admitted was for security. He advised that a bone scan would be made to make sure there was nothing going on and referred appellant to a specialist. Dr. Meyer prescribed Darvocet.

In a May 3, 1999 radiology report, Dr. Wanda Bernreuter, a Board-certified diagnostic radiologist, found a healed right proximal shaft fracture present. She noted that the apex angulation was slightly toward the posterior and lateral sides, and that there was mild cartilage narrowing at the medial joint line of the knee. Dr. Bernreuter further noted mild diffuse osteopenia.

In a May 13, 1999 bone scan, Dr. Johnny Scott, Board-certified in nuclear medicine and pathology, found post-traumatic changes in the proximal right tibia and degenerative joint disease in both knee joints.

In a May 14, 1999 report, Dr. David A. Volgas, an orthopedic surgeon, stated that a physical examination of appellant showed a full range of motion for the knee as well as the ankle. He noted a 2 to 2.5 centimeter leg length discrepancy, for which he wore a ¾ heel lift. Dr. Volgas noted that appellant did not have any pain when he stressed the fracture site varus or valgus. He did not have any knee varus or valgus instability. Dr. Volgas reported that appellant has a negative drawer, negative Lachman's negative pivot-shift, no tenderness along the joint line and his patella was normal. He has point tenderness in the lateral aspect of the fracture, but it is unpredictable where it is, depending on where he pushes. Dr. Volgas' radiographs demonstrated a healed fracture in relatively good alignment, with about five degrees of varus and minimal recurvatum. His bone scan showed minimal uptake at this old fracture site. Dr. Volgas' impression was painful right leg. He also opined that he had discussed appellant's situation with him in detail and determined that his balance problems may well be inner ear and not related to his leg, since he did not have a history of hearing loss. Dr. Volgas opined that appellant was not totally disabled and should be able to find a job doing some type of activity. He further advised that a functional capacity examination would be worthwhile.

By letter received on May 24, 1999, appellant requested an oral hearing, which was held on October 20, 1999.

In a decision dated January 12, 2000, an Office hearing representative affirmed the Office's April 26, 1999 termination of benefits, finding that appellant was no longer disabled for the battery repairer job that he held on the date of injury.

In a December 13, 1999 report, Dr. William Pillow, a general surgeon, noted appellant's history of injury and treatment. His physical examination of the right knee showed an overall slightly varus alignment to his right tibia. Dr. Pillow stated that he was significantly shorter on his right tibia compared to his left and he had medial joint line tenderness in the right knee with minimal effusion. He had 0 to 125 degrees of range of motion in his right knee and was stable to varus and valgus stress with fairly soft end point on his Lachman. Dr. Pillow found a negative pivot secondary to guarding. His impression was right knee medial joint line pain and status post right tib/fib fracture with malunion. Dr. Pillow addressed the question of whether his initial forklift injury could have caused his knee pain and the problems associated with his knee now. He opined that it was impossible for him to say as he had not examined appellant right after the tib/fib fracture. Dr. Pillow further stated that it was possible that the trauma that it took to cause a tib/fib fracture could very easily have caused him to have a meniscal tear. Additionally, with his varus union of his tibia, he is putting a lot more stress on the medial aspect of his joint, which

does cause this to have accelerated degeneration. Dr. Pillow stated that he did not even think that spending the extended period in a cast would cause the meniscal problems.

In a January 26, 2000 report, Dr. Jerry M. Bynum noted that appellant was being seen for major depression. Dr. Bynum stated that appellant reported his leg was seriously injured when he became caught between a forklift and a truck. He noted that appellant had a compound fracture that required 14 days of hospital care and 2 years in a full leg cast. Dr. Bynum stated that, since the accident, appellant experienced nightmares of the event three to four times per week on average. He stated that appellant was conscious during the event and often dreams of or remembers the sight of his leg after the accident. Dr. Bynum stated that, while most of the problems associated with the event were in the form of nightmares, he also experienced problems when seeing a forklift. He stated that appellant would try to avoid places where he knew that he would see a forklift and quickly left any place when there was one that he had not anticipated. Dr. Bynum stated that appellant avoided walking between vehicles. He diagnosed major depression in the severe range and post-traumatic stress disorder.

In an April 28, 2000 reissuance of decision, the hearing representative found that a December 13, 1999 report had not been reviewed prior to the issuance of its decision. The representative also noted the January 26, 2000 report from Dr. Bynum, but acknowledged that this was after the decision and did not include this in his analysis. The hearing representative incorporated the January 12, 2000 decision into its reissuance in its entirety, which affirmed the April 26, 1999 termination of benefits.

Appellant filed a request for reconsideration on July 12, 2000. He enclosed the January 26, 2000 report from Dr. Bynum and Dr. Pillow's December 26, 1999 report.

In a decision dated September 28, 2000, the Office found the arguments and evidence submitted to be of a repetitious and immaterial nature and therefore insufficient to warrant merit review of the claim.

The Board finds that the Office properly terminated appellant's compensation.

Once the Office 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.[1] After it has determined that an employee has disability causally related to his or her federal employment, the Office may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment.[2] Furthermore, the right to medical benefits for an accepted condition is not limited to the period of entitlement for disability.[3] To

[1] *Lawrence D. Price*, 47 ECAB 120 (1995).

[2] *Id; see Patricia A. Keller*, 45 ECAB 278 (1993).

[3] *Furman G. Peake*, 41 ECAB 361, 364 (1990).

terminate authorization for medical treatment, the Office must establish that appellant no longer has residuals of an employment-related condition which require further medical treatment.[4]

In assessing medical evidence, the weight of such evidence is determined by its reliability, its probative value and its convincing quality. The opportunity for and thoroughness of examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of the analysis manifested and the medical rationale expressed in support of the physician's opinion are facts which determine the weight to be given each individual report.[5]

In the instant case, the Office terminated appellant's compensation benefits based upon the report of appellant's attending physician, Dr. Meyer. At the time of termination, the only medical reports of record were from appellant's attending physicians. The Office allowed appellant 30 days, after notice of proposed termination, to submit current medical evidence from his attending physician, but no new evidence was submitted.

Dr. Meyer's February 20, 1997 report carried the weight of the medical evidence as it was the only current medical evidence of record, which addressed appellant's ability to return to work. In his report, he stated that appellant was there with a caseworker to determine if he could return to work, and if so, in what capacity. Dr. Meyer discussed appellant's pain condition as opposed to three years ago and asserted that it was not the same pain, that appellant had pain when the weather changed and stated that appellant could not squat. He described the degrees of extension in appellant's leg as going from 0 to greater than 120, with some mild varus and some degree of hyperextension in his knee. Dr. Meyer stated that the leg was still mildly short. He noted that x-rays of the tibia showed that this fracture was very solid with only about 10 to 15 degrees of recurvatum at the mid-shaft and only in minimal varus. Dr. Meyer concluded his report by indicating that appellant could return to the job description that he has given me at the battery shop, without significant limitations, with the exception of squatting. He further stated that appellant could do continuous sitting, intermittent walking, lifting, bending, climbing, twisting and standing, but no squatting and less than one hour of kneeling a day. Dr. Meyer further placed a 50-pound lifting restriction on appellant and stated that appellant was at maximum medical improvement. In October 1997, he saw appellant and stated that his February 20, 1997 report was still accurate.

Appellant submitted other reports consisting of a February 25, 1999 radiology report from Dr. Lopez, indicating his fracture was healed and a slight posterior apex angulation of both bones was noted. In a February 25, 1999 report, Dr. Meyer stated that appellant returned with pain in the right proximal tibia. He found appellant's leg to be one-half inch shorter on the right and prescribed a heel lift. In a May 3, 1999 report, Dr. Meyer stated that appellant was complaining of pain in the tibia fracture area of the break and referred appellant for a bone scan and a specialist to be sure that nothing was going on. In a May 3, 1999 radiology report, Dr. Bernreuter found a healed right proximal shaft fracture present, with some narrowing and

[4] *Id.*

[5] *See Connie Johns*, 44 ECAB 560 (1993).

mild diffuse osteopenia. Additionally, in a May 13, 1999 bone scan, Dr. Scott made a diagnosis of post-traumatic changes in the proximal right tibia and degenerative joint disease in both knee joints. Furthermore, in a May 14, 1999 report, Dr. Volgas, also one of appellant's attending physicians, opined that appellant was not totally disabled and should be able to find a job doing some type of activity. He also advised a functional capacity examination. However, none of these physicians addressed appellant's ability to work or indicated that he was disabled.

In a December 13, 1999 report, Dr. Pillow noted appellant's history of injury and treatment and opined that it was impossible to determine whether appellant's knee pain and problems associated with the knee now were related as he had not examined appellant after the initial fracture. He opined that it was possible for a meniscal tear to occur with this type of injury. Dr. Pillow did not address whether appellant was disabled at present or whether appellant could perform any type of work. The Board has held that an opinion, which is speculative in nature, has limited probative value in determining the issue of causal relationship.[6]

The Office properly relied upon the February 20, 1997 report of Dr. Meyer in determining that appellant was capable of performing the duties of his date-of-injury position and was not entitled to further compensation benefits for disability. Disability means the inability to earn the wages the employee was receiving when injured.[7] If an employee no longer has an impairment which prevents him from performing the job he held when injured, he is no longer disabled[8] and is not entitled to compensation for loss of wage-earning capacity.[9] As Dr. Meyer reviewed the description of appellant's date-of-injury position and provided a clear opinion explaining the extent of appellant's physical impairments and opined that appellant could perform the position, the Office properly relied upon the report to terminate appellant's continuing compensation benefits. As the weight of the medical evidence before the Office at the time of its April 28, 2000 decision, establishes that appellant was no longer disabled, the Board finds that the Office met its burden of proof to terminate appellant's wage-loss compensation benefits effective April 25, 1999.

The Board finds, however, that this case is not in posture for a decision on the issue of whether appellant has established any continuing disability after April 25, 1999 causally related to his accepted employment conditions.

As the Office met its burden of proof to terminate appellant's compensation benefits, the burden shifts to appellant to establish that he has a disability causally related to his accepted employment injury.[10] To establish a causal relationship between the condition, as well as any disability claimed and the employment injury, the employee must submit rationalized medical opinion evidence, based on a complete factual background, supporting such causal relationship.

[6] *Arthur P. Vliet*, 31 ECAB 366 (1979).

[7] *Gregory A. Compton*, 45 ECAB 154 (1993).

[8] *Patricia A. Keller*, 45 ECAB 278 (1993).

[9] *Clement Jay After Buffalo*, 45 ECAB 707 (1994).

[10] *George Servetas*, 43 ECAB 424, 430 (1992).

Rationalized medical opinion evidence is medical evidence, which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. 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 claimant. 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.[11]

In support of his request for reconsideration, appellant submitted medical evidence from Dr. Bynum, which indicated that appellant was seen for major depression. Dr. Bynum noted appellant's history of injury and treatment, including the fact that appellant was conscious during the event and often dreamt of his leg as he remembered it at the sight of the accident and diagnosed severe post-traumatic stress disorder. He stated that most of appellant's problems were in the form of nightmares, occurring three to four times a week on average and explained that the sight of a forklift also contributed to his condition. If this were the case, then it would not be possible for appellant to perform his preinjury position. The Board finds that, while Dr. Bynum's report is not sufficiently rationalized, it is sufficient to raise an inference that appellant continues to suffer from an employment-related disability. A psychological condition has not been accepted by the Office.

Proceedings under the Federal Employees' Compensation Act are not adversarial in nature, nor is the Office a disinterested arbiter. While a claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence to see that justice is done.[12]

In order to resolve this, the Office should refer appellant, the medical record and a statement of accepted facts to a physician in the appropriate specialty. The statement of accepted facts should clearly set forth the injuries and conditions accepted by the Office. The specialist should submit a rationalized medical report setting forth the findings on examination and address whether appellant continues to suffer from employment-related disability, in particular a psychological condition. Following such development, as the Office deems necessary, the Office should issue an appropriate decision.

[11] *James Mack*, 43 ECAB 321 (1991).

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

The September 28, 2000 decision of the Office of Workers' Compensation Programs is hereby set aside and the case remanded to the Office for further proceedings consistent with this decision of the Board. The decision of the Office dated April 28, 2000 is hereby affirmed.

Dated, Washington, DC
April 1, 2002

Alec J. Koromilas
Member

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member