U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of WILLIAM H. BUTLER and DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Pittsburgh, PA

Docket No. 01-1463; Submitted on the Record;
Issued May 29, 2002

DECISION and ORDER

Before COLLEEN DUFFY KIKO, WILLIE T.C. THOMAS, MICHAEL E. GROOM

The issue is whether the Office of Workers' Compensation Programs properly terminated appellant's wage-loss compensation on the grounds that his accepted employment injury no longer disabled him for work.

On May 12, 1997 appellant, then a 49-year-old housekeeping aid, fractured his right femoral neck when he tripped and fell at work. The Office accepted his claim and authorized an open reduction with internal fixation. Appellant received compensation for temporary total disability.

Appellant's attending physician, Dr. Douglas Skinner, a family practitioner, reported on October 17, 1997 that he continued to suffer chronic hip pain and decreased range of motion. He diagnosed a fractured femur with incomplete recovery and referred appellant to Dr. Michael A. Tranovich, an orthopedist.

On October 28, 1997 Dr. Tranovich reported slow progress in appellant's recovery, with persistent pain and tenderness. On December 15, 1997 Dr. Tranovich diagnosed status post open reduction and internal fixation with lateral bursitis and possible avascular necrosis.[1] He released appellant to light duty.

Appellant returned to light duty on December 15, 1997 but missed work intermittently due to hip pain. Dr. Skinner referred appellant to Dr. Arnold S. Broudy, an orthopedist, who examined appellant on February 9, 1998 and diagnosed status post open reduction and internal fixation of right hip fracture. He referred appellant to an associate, Dr. Michael Levine, an orthopedic surgeon, for an opinion on the etiology of appellant's pain.

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[1] On January 13, 1998 Dr. Tranovich reported that a bone scan on December 19, 1997 showed no gross evidence of avascular necrosis.

On February 27, 1998 Dr. Levine noted that appellant's persistent pain had worsened since his injury. He diagnosed trochanter bursitis secondary to painful hardware, right hip and recommended removal of the hardware one-year status post injury.

The Office referred appellant, together with the medical record and a statement of accepted facts, to Dr. Subrata Barua, an orthopedic surgeon, for a second opinion. On April 3, 1998 he reported: "Status post Open Reduction Internal Fixation for a fracture of the neck of the right femur with residual, persistent right hip pain. Rule out vascular necrosis of the femoral head. Also right hip pain due to the hardware in the right hip." Dr. Barua reported that the cause of appellant's pain was difficult to explain. The fracture of the neck of the right femur was healed and x-rays of the right hip had so far shown no evidence of avascular necrosis of the right femoral head. It was Dr. Barua's opinion that appellant had some residual pain. He reported that removing the internal fixation devices should be strongly considered to see whether that relieved the pain. Dr. Barua advised that appellant was not able to return to his preinjury job as a housekeeping aid but was able to do the light-duty work to which he had returned in December 1997.

On May 7, 1998 Dr. Levine diagnosed trochanteric bursitis secondary to painful hardware, right hip. He performed surgery that day to remove the hardware. On May 13, 1998 Dr. Levine reported that appellant's surgery required extensive dissection. He anticipated that appellant would be able to work full duty in about three months.

On July 17, 1998 Dr. Levine advised Dr. Skinner that appellant was still complaining of trochanteric discomfort and still had an antalgic gait.

The Office referred appellant back to Dr. Barua. In a report dated August 4, 1998, Dr. Barua diagnosed status post healed fracture neck of the right femur and status post removal of hardware of the right hip with residual right hip pain. He reported that the cause of the pain was unknown:

> "Several facts should be considered in this case since the cause of the pain cannot be determined. It is an established fact that he did have a fracture[d] neck of the right femur, which has healed according to radiographic examination. The hardware, which was thought to be the cause of his pain source, was removed but there is residual pain. [Appellant] complained of pain in his right hip.
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> "The history of pain as described by [appellant] does not coincide with the type of pain medication that [appellant] takes occasionally. [Appellant] described the pain of being an 8 on a pain scale of 0 [to] 10 and does not correlate with the mild pain medication he has been taking occasionally. The only visible and positive sign is that he does have a ½ inch shortening of the right leg from this fracture but that should not cause any disability. As far as the Trendelenburg gait that he is showing at this time is from the gluteus medius muscle deficiency, which could cause this type of gait. But again, this should not cause the pain.
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> "[Appellant] has been taking physical therapy for the past 6 [to] 8 weeks which so far, according to [him], has not helped his pain. Based on the clinical findings, I

could not find any cause for the dull right hip pain at this time. I felt that the fracture has healed and there [are] no present findings of any avascular necrosis of the femoral head. He has some residual gluteus medius weakness, which causes the Trendelenburg gait.

"During the daily cleaning job from 7:00 A.M. to 3:30 P.M. and the type of activities that are required, I feel that [appellant] will be able to return to that type of job at this time. One contraindication of returning to that job is to avoid long continuous standing and walking for three to four hours which I do not see in the daily work activities of cleaning. [Appellant] … does suffer a subjective residual dull pain in the right hip at this time."

On August 5, 1998 Dr. Levine reported that when he last saw appellant in July he was concerned about appellant's slow progress following removal of the hardware. Although the plan was to release appellant to full duty in six weeks' time, he was currently capable of only light duty. On August 26, 1998 Dr. Levine reported that appellant was still having pain, that it was a little worse and that it was primarily over the abductors and the trochanter. "I am really at a loss to explain his symptoms," Dr. Levine stated, "I doubt that there is much more to do orthopedically right now." He referred appellant to Dr. Brian M. Ernstoff, a physiatrist, for further evaluation and treatment.

The Office asked Dr. Levine whether appellant was released to return to full duty. On September 2, 1998 Dr. Levine replied: "[Appellant] remains unchanged. His pain was actually worse on the last visit. I took the liberty to refer him to Dr. Brian Ernstoff, a physiatrist, for there is nothing more to offer from an orthopedic standpoint. He was not released to full-duty at work."

The Office provided Dr. Levine a copy of Dr. Barua's report of August 4, 1998 and asked for an opinion on whether he concurred with Dr. Barua's evaluation. On September 23, 1998 Dr. Levine replied as follows: "I concur with Dr. Barua's opinion, for I cannot find a good source for [appellant's] residual hip pain as well. In terms of his ability to return to full-duty work, that would obviously depend on his pain tolerance, for there is no objective reason that he could not."

On September 24, 1998 Dr. Ernstoff diagnosed ambulation dysfunction, hip pain and status post removal of hardware, right hip. He recommended reinitiating physical therapy and indicated that appellant was not able to return to his preinjury job without restriction. On October 16, 1998 Dr. Ernstoff reported that appellant was not doing very well with his therapy. He reported that the cause of appellant's ongoing pain was unclear. Dr. Ernstoff recommended that appellant continue with his medication but reported that he did not see the need to continue with the therapy program. He downgraded appellant's prognosis from good to fair and again indicated that appellant was not able to return to his preinjury job without restriction.

On October 21, 1998 Dr. Levine reported that he had examined appellant that day and that appellant was "no better whatsoever." He referred appellant to a pain clinic for a differential epidural block, which he stated might help sort things out. Dr. Levine completed a disability

certificate indicating that appellant had recovered sufficiently to be able to return to light duty on October 22, 1998.

On March 5, 1999 Dr. Levine advised Dr. Skinner as follows:

> "[Appellant] was examined in the office on March 5, 1999. Apparently he could not be helped at the Pain Clinic. I do not have the results, unfortunately, of the differential epidural block today. He has been having some problems with the diabetic foot ulcer on the right foot and has subsequent swelling as well of the leg. My feeling is that there is really nothing much that can be done more with the hip at the present time. His flexion is 90, abduction is 40, adduction is 20, internal rotation is 10 and external rotation is 30 without pain. His x-rays look fine, just the screw holes are present. There is no significant arthritis of the joint. I really do [no]t have much more to offer him. He is applying for [s]ocial [s]ecurity [d]isability. I think I would place him somewhere at the sedentary level, possibly light only. I think that some of the present problems could be related to the diabetic foot as well."

Dr. Skinner completed disability slips indicating that appellant was unable to work due to recurrent severe hip pain. On July 26, 1999 he reported that chronic disability was expected "per orthopedic surgeon's report." Dr. Skinner indicated that it was not known when appellant would be able to resume regular duty.

In a decision dated September 10, 1999, the Office terminated appellant's compensation for wage loss. The Office found that the weight of the medical evidence rested with the August 4, 1998 report of Dr. Barua, the Office referral physician, who advised that appellant could return to full duty. The Office noted that appellant's attending orthopedic specialist, Dr. Levine, had reviewed Dr. Barua's report and had agreed with his opinion that appellant could return to full duty.

In a decision dated June 20, 2000, an Office hearing representative affirmed the termination of appellant's compensation for wage loss. The hearing representative noted that both Drs. Barua and Levine had reported that appellant could return to full duty. The hearing representative found, however, that appellant remained entitled to medical benefits for such injury-related residuals as the shortening of the right leg, gluteus medius weakness causing a Trendelenburg gait and mild to moderate arthrosis.

The Board finds that the Office has not met its burden of proof to justify the termination of appellant's compensation for wage loss.

Once the Office accepts a claim, it has the burden of proof to justify termination or modification of compensation benefits.[2] After it has determined that an employee has disability causally related to his or her federal employment, the Office may not terminate compensation

[2] *Harold S. McGough*, 36 ECAB 332 (1984).

without establishing that the disability has ceased or that it is no longer related to the employment.[3]

The Office has mistakenly interpreted Dr. Levine's September 23, 1998 report as a release for appellant to return to full duty. This interpretation is inconsistent with Dr. Levine's opinion both before and after September 23, 1998 that appellant was not able to return to full duty.

Dr. Levine, the attending orthopedic surgeon, agreed with Dr. Barua, the Office referral physician, insofar as neither could find a good source for appellant's residual hip pain. Dr. Levine, however, did not release appellant to full duty. He reported that appellant's ability to return to full duty would obviously depend on his pain tolerance. Earlier, the Office asked Dr. Levine directly whether appellant was released to return to full duty. Dr. Levine replied on September 2, 1998 that appellant was not released for full duty. He referred appellant to a physiatrist, Dr. Ernstoff, who in turn reported on September 24, 1998 that appellant was not able to return to his preinjury job without restriction. On October 21, 1998 Dr. Levine reported that appellant was "no better whatsoever." He completed a disability certificate indicating that appellant had recovered sufficiently to be able to return to light duty. In a closing report dated March 5, 1999, Dr. Levine advised Dr. Skinner, appellant's attending family practitioner and primary care physician, that he really had nothing more to offer appellant. Dr. Levine advised Dr. Skinner that he would place appellant "somewhere at the sedentary level, possibly light only." Dr. Skinner subsequently completed disability slips and form reports supporting that appellant was unable to work due to recurrent severe hip pain.

Dr. Levine, thus, did not agree with Dr. Barua on the issue of disability for work. Dr. Barua is the only physician in this case who, prior to the termination of compensation, found that appellant was able to perform his duties as a housekeeping aid.

The Board finds that there is a conflict between appellant's attending physicians and the Office referral physician on whether appellant's accepted employment injury continues to disable him from his date-of-injury position as a housekeeping aid. Because the conflict in medical opinion is unresolved, the Office did not meet its burden of proof to justify the termination of appellant's compensation for wage loss.

[3] *Vivien L. Minor*, 37 ECAB 541 (1986); *David Lee Dawley*, 30 ECAB 530 (1979); *Anna M. Blaine*, 26 ECAB 351 (1975).

The June 20, 2000 decision of the Office of Workers' Compensation Programs is reversed on the termination of compensation for wage loss.

Dated, Washington, DC
May 29, 2002

Colleen Duffy Kiko
Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member