U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of VINCENT J. LANUTO and DEPARTMENT OF VETERANS AFFAIRS, PUGET SOUND HEALTHCARE SYSTEM, Seattle, WA

Docket No. 03-1320; Submitted on the Record;
Issued July 28, 2003

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
MICHAEL E. GROOM

The issue is whether the Office of Workers' Compensation Programs met its burden of proof to terminate appellant's compensation benefits effective March 7, 2003.

On August 6, 2001 appellant, then a 42-year-old carpenter, filed a claim for traumatic injury alleging that on August 2, 2001 he sustained injuries to his back and left ankle when he slipped and fell in the performance of duty. The Office accepted his claim for a lumbar strain and left ankle strain. Appellant stopped work on August 2, 2001 and did not return. On March 15, 2002 he underwent surgical left gastrocnemius muscle lengthening to correct a contracture. This procedure was accepted by the Office as causally related to the employment injury.

By letter dated December 18, 2002, the Office proposed to terminate appellant's compensation benefits. In a decision dated March 7, 2003, the Office terminated his compensation and medical benefits effective that date. By letter dated March 18, 2003, appellant submitted additional evidence and asked that the Office please consider allowing him to undergo work hardening. In a letter dated April 3, 2003, the Office acknowledged his correspondence and advised him to follow the appeal rights which accompanied the March 7, 2003 decision.

The Board finds that the Office met its burden of proof to terminate appellant's compensation benefits.

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

[1] *Gloria J. Godfrey*, 52 ECAB 486 (2001); *Mohamed Yunis*, 42 ECAB 325, 334 (1991).

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

In this case, the record contains numerous medical reports and progress notes from appellant's treating physicians. X-rays of his foot performed on August 14, 2001, shortly after the injury, were normal. X-rays of appellant's lumbar spine showed only a mild loss of disc height at L4-5 and a magnetic resonance imaging (MRI) scan of the left ankle performed on October 1, 2001 was negative for tendon disruptions. An MRI scan of appellant's lumbar spine performed on February 21, 2002 also showed only degenerative disc disease at L4-5 and L5-S1.

In a report dated April 2, 2002, Dr. Gary L. Henriksen,[5] appellant's treating physician, diagnosed a lumbar sprain with marked pain behavior and noted that the pain location was not consistent with either dermatomes or known pain patterns. In a report dated April 12, 2002, Dr. Peter E. Krumins, appellant's Board-certified orthopedic surgeon, stated that one month post surgery, appellant was healing well and was improving. He diagnosed status post left gastrocnemius lengthening, left ankle sprain, stable and left plantar fasciitis, stable. Dr. Krumins stated that appellant should restart physical therapy and anticipated his return to work in the range of four to six weeks. In a report dated June 18, 2002, Dr. Henriksen noted that appellant presented that date complaining that he had sustained an additional injury to his left wrist. Appellant reported that a cramp in his left calf caused him to slip and fall while getting out of the bathtub and stated that he hurt his left wrist attempting to catch himself. Dr. Henriksen diagnosed appellant with a left wrist sprain. X-rays of appellant's left wrist taken on June 19, 2002 were normal.[6] Approximately four months after his gastrocnemius lengthening surgery, in a report dated July 2, 2002, Dr. Henriksen stated that he was at a loss to explain appellant's subjective back and wrist pain, in light of the fact that all x-rays were normal and the MRI scan showed only degenerative disc disease commensurate with appellant's age and occupation. He requested approval for a medical consultant to obtain a second opinion, which was granted by the Office on July 10, 2002. In a report dated July 30, 2002, Dr. Steven Litsky, a Board-certified physiatrist to whom appellant was referred by Dr. Henriksen, examined appellant and diagnosed nascent chronic pain syndrome, cervical thoracic and lumbar strain and sprain, following the industrial accident, left ankle tendon disruption with subsequent surgery following industrial accident and probable depression. Dr. Litsky recommended that appellant enter a pain

[2] *Id.*

[3] *Franklin D. Haislah*, 52 ECAB 457 (2001); *Furman G. Peake*, 41 ECAB 361, 364 (1990).

[4] *Id.*

[5] Dr. Henriksen is Board-certified in preventive medicine.

[6] In a decision dated January 22, 2003, the Office denied appellant's claim for a consequential left wrist injury, on the grounds that appellant had failed to submit comprehensive medical and factual information, as requested by the Office in its letter dated July 3, 2002. He did not appeal this decision to the Board.

management or work-conditioning program, but added that if these were not approved, physical therapy should provide maximum medical improvement within eight to ten weeks.

On June 23, 2002 the Office referred appellant, together with a statement of accepted facts, the medical opinions of record and a list of issues to be addressed, to Dr. Richard G. McCollum, a Board-certified orthopedic surgeon, and Dr. G.A. DeAndrea, a Board-certified neurologist, for a second opinion evaluation. In a combined report dated August 5, 2002, Dr. McCollum listed his findings on physical examination, noting that appellant was in no acute distress but walked with a marked antalgic gait on the left side, with irregular cadence, was unable to walk on heels or toes or tandem walk on the left and could not do the Trendelenburg's test on the left. The Romberg test was negative. Lumbar flexion was 70 degrees and extension was 10 degrees. Lumbar tilt was 30 degrees left and right and lumbar rotation was 45 left and right. Calf measurement was 42 centimeters on the left and 43.5 on the right. Ankle circumferences were 26.8 bilaterally and midfoot circumferences were 27 centimeters bilaterally. Thigh circumference was 48.4 centimeters on the left and 49 on the right. Appellant's surgical scar was well healed and nontender, with no apparent redness or swelling about the foot or ankle, but he had a slight lump in the posterior lateral gastrocnemius and another lesion on the lateral side of the leg which was fusiform in size and had an elevation of about four millimeters. This area was swollen to the diameter of about a quarter and was minimal with no redness. The Achilles tendon was intact, with no masses or tenderness. Examination of the left ankle revealed no instability on examination and drawer sign was negative. Dorsiflexion was five degrees bilaterally, plantar flexion 35 degrees bilaterally, inversion 30 degrees bilaterally and eversion was 5 degrees bilaterally. Supine and sitting straight leg raising produced tight hamstrings at 70 degrees bilaterally, without pain. Wrists appeared symmetric, with no redness, swelling, instability, deformity or tenderness. Dorsiflexion was 50 degrees and volar flexion was 70 degrees, bilaterally. Ulnar flexion was 35 degrees and radial deviation was 15 degrees bilaterally. Circulation and pulses, skin texture and warmth of the hands were normal. Tinel's and Phalen's signs were negative bilaterally. Arm circumference was 41 centimeters on the dominant right side and 40.5 on the left. Forearm circumference was 36 centimeters on the right and 34 on the left.

Dr. DeAndrea also noted his neurological findings, noting that he had confined his examination to the lower extremities. He advised that there was no gross visible atrophy or fasciculation and while appellant had some relative alopecia over his left anterolateral distal leg and ankle, attributable to his ankle brace, he had no other vascular or temperature changes suggestive of complex regional pain syndrome. Manual motor testing was 5/5 in all groups and appellant was noted to have inconsistent giveway weakness when testing his left foot, particularly foot dorsiflexion, extensor hallucis longus and extensor digitorum brevis, which normalized upon encouragement. Sensory examination was subjectively reduced to light touch over the dorsum of the left fourth and fifth toes. Temperature was the same as light touch and pinprick over the same region with additional variable and poorly reproducible reduced pinprick over the left lateral foot and ankle. Deep tendon reflexes were three+ symmetric patellar and two+ symmetric Achilles, with normal plantar cutaneous responses and notable absence of ankle clonus.

After reviewing the medical records and test results, the physicians diagnosed lumbar and left ankle strains, due to the injury of August 2, 2001. They stated that there was no abnormality

of the left wrist and noted that the medical records did not suggest that appellant had any wrist injury of any significance. They further stated that there were no objective medical findings to indicate that appellant had any other condition related to the August 2, 2001 injury, other than the question of the gastrocnemius contracture, which they were not sure had been accepted by the Office and there was no evidence of any aggravation of a preexisting condition. The physicians added that there was no explanation for why appellant had ongoing symptoms and noted that there were no objective findings to justify any further diagnostic or therapeutic measures. The physicians concluded that appellant's conditions, causally related to his August 2, 2001 injury, had resolved, that there was no need for further medical treatment and that appellant could return to the work he was performing at the time of his August 2, 2001 injury. In a supplemental report submitted at the Office's request, Dr. McCollum clarified that, on evaluation on August 5, 2002, there was no residual lumbar or left ankle strain or right Achilles tendinitis. He also stated that he now understood that the left gastrocnemius surgery had been accepted by the Office as causally related to the employment injury, but that did not change his opinion that appellant required no further treatment and could return to work as a carpenter without restrictions.

In a report dated September 23, 2002, Dr. Henriksen stated that he had reviewed the report of Drs. McCollum and DeAndrea and had discussed it with appellant. He noted that Drs. McCollum and DeAndrea had found appellant fixed and stable, not in need of any further therapeutic or diagnostic steps and able to return to work. Dr. Henriksen stated that appellant reported that, in contrast, Dr. Krumins had initially raised the possibility of more surgery if additional aggressive physical therapy did not improve appellant's ankle. Dr. Henriksen stated that he indicated to appellant that he could not really rebut the report of Drs. McCollum and DeAndrea based upon his own observations and that if Dr. Krumins believed appellant required additional physical therapy or surgery, he would have to make that case to the Office himself.

In a report dated October 14, 2002, Dr. Krumins stated that appellant continued to exhibit swelling of unknown cause and chronic pain and recommended that appellant undergo a diagnostic MRI scan. He stated that appellant's gastrocnemius contracture was much improved and added that appellant would benefit from work hardening or work conditioning to improve his activity level. An MRI scan of appellant's left calf, performed on November 5, 2002, was normal, with no evidence of soft tissue mass, hematoma, muscle laceration, bone marrow edema or contusion. In a report dated November 12, 2002, Dr. Krumins diagnosed status post left gastrocnemius lengthening and left ankle sprain, stable and noted that the MRI scan results looked good. He added that he could not detect any obvious problems in the lower leg except for some transient weakness and atrophy, which hopefully would improve over time. Dr. Krumins recommended a work-hardening program, which would hopefully allow appellant to return to more regular work activities.

In a report dated December 11, 2002, Dr. Krumins again noted that appellant had limited strength and endurance and stated that a work-hardening program would be quite helpful. He added that it was puzzling to him why this had not been approved, when essentially over the last month appellant had not made any gains and was still limited in what he could do. Dr. Krumins added that further delays in work hardening had no logical basis and that if work hardening had been approved when initially requested, appellant would be back at work already. In an accompanying work capacity evaluation form, OWCP-5, Dr. Krumins indicated that he

disagreed with Drs. McCollum and DeAndrea, that appellant could not return to work without work hardening and that currently appellant was restricted from lifting more than ten pounds and from lifting, walking, standing, squatting, kneeling or climbing for more than two hours. In a letter to the Office dated December 12, 2002, Dr. Krumins reiterated that appellant had decreased strength and endurance and that a work-hardening program would be helpful to him and would hasten his return to work. In a report dated January 10, 2002, he noted that appellant had made some improvement working on strengthening on his own, but would still benefit from a work-hardening program.

The Board finds that the weight of the medical opinion evidence rests with the well-rationalized reports of Drs. McCollum and DeAndrea. Drs. McCollum and DeAndrea provided a history of injury and appellant's medical history, reviewed the results of early tests and performed a complete physical examination. They noted that there were no objective signs of appellant's accepted lumbar strain or left ankle sprain and stated that they felt these conditions had resolved. They also found that appellant would not benefit from any additional therapeutic or diagnostic treatment and that he could return to his regular job as a carpenter, eight hours a day. The report of Dr. McCollum and DeAndrea is in accord with that of Dr. Henriksen, appellant's primary treating physician, who stated that based on his own observations, he could not rebut their findings. In contrast, Dr. Krumins stated that appellant required a work-hardening program before he could return to work. While he noted that appellant had decreased strength and endurance, he did not specifically explain why a work-hardening program was necessary, other than to say it would be beneficial. He also did not specify whether the work-hardening program was merely a prophylactic measure or was medically necessary.[7] Finally, Dr. Krumins did not explain why a formal work-hardening program would be better for appellant than simply performing some strengthening exercises on his own, without a formal program. This is especially important as Dr. Krumins noted that appellant's condition had improved when he started exercising on his own. Therefore, as Dr. Krumins did not offer any rationalized explanation as to why appellant could not return to work without participating in a formal work-hardening program, his report is of diminished probative value.[8] As Drs. McCollum and DeAndrea stated that appellant had no objective signs of his accepted conditions and further stated that he could return to work without further treatment and without restrictions and as their opinion is in accord with the opinion of Dr. Henriksen, appellant's primary treating physician, the Office properly relied on their opinions and met its burden of proof to terminate appellant's compensation benefits effective March 7, 2003.

[7] *See Mary Geary*, 43 ECAB 300, 309 (1991); *Pat Lazzara*, 31 ECAB 1169, 1174 (1980).

[8] *Robert Lombardo*, 40 ECAB 1038 (1989).

The decision of the Office of Workers' Compensation Programs dated March 7, 2003 is hereby affirmed.[9]

Dated, Washington, DC
July 28, 2003

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member

[9] The Board notes that, subsequent to the Office's March 7, 2003 decision, appellant submitted additional reports from Dr. Krumins dated March 10 and 27, 2003 and asked that the Office again consider approving a work-hardening program. The Office did not issue a decision on appellant's request, but rather acknowledged appellant's letter and instructed him to follow his appeal rights. As the Board's review is limited to the evidence that was before the Office at the time it issued its final decision, the Board cannot consider these reports. *Charles P. Mulholland, Jr.*, 48 ECAB 604 (1997); *Robert D. Clark*, 48 ECAB 422 (1997).