United States Department of Labor
Employees' Compensation Appeals Board

M.K., Appellant	)	
and	)	**Docket No. 10-1572**
	)	**Issued: May 23, 2011**
U.S. POSTAL SERVICE, CLEVELAND ANNEX, Cleveland, OH, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 25, 2010 appellant, through her attorney, filed a timely appeal from the May 6, 2010 decision of the Office of Workers' Compensation Programs affirming the termination of wage-loss compensation and certain medical benefits. Pursuant to the Federal Employees' Compensation Act[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether the Office met its burden of proof to terminate appellant's compensation benefits and certain medical benefits effective May 6, 2010.

On appeal, appellant's attorney contends that the Office's decision is contrary to fact and law.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On June 24, 1997 appellant, then a 39-year-old casual clerk, filed a traumatic injury claim alleging that on that date she sustained an injury to her right leg when a colleague rolled a bulk mail carrier into her by mistake. The Office accepted a right leg contusion/laceration, tear of the Achilles tendon, tendinitis and right leg cellulitis. It paid medical and wage-loss compensation benefits. Appellant underwent approved surgery to repair her right Achilles tendon on October 23, 2000. She did not return to work.

In a report dated November 8, 2008, Dr. Franklin B. Price, a treating physician, stated that, as a result of the June 24, 1997 employment injury, appellant had diminished range of motion and pain upon motion with paravertebral lumbar muscle spasm and pain upon dorsiflexion and plantar flexion of the right foot. He opined that she was unable to work.

On January 20, 2009 the Office referred appellant to Dr. Robert M. Furnich, for a second opinion. In a February 5, 2009 report, Dr. Furnich found that she did have any residuals of the work-related injury. He found no signs of active or single episode of prior cellulitis or of active tendinitis. Dr. Furnich noted that the partial Achilles tendon had been repaired and there was no functional residual with regard to the Achilles tendon. The sole physical finding, which was more subjective than objective, was sensitivity to the posterior incision. Dr. Furnich opined that appellant was totally disabled due to unrelated medical conditions and needed a functional capacity evaluation to determine her restrictions in all capacities.

In a March 3, 2009 report, Dr. Price noted that examination of the right ankle area revealed that the right Achilles tendon area remained quite swollen and tender compared to the left. Appellant had considerable pain upon palpitation of this area that was severe enough that she walked with a cane. Dr. Price found that she was still disabled from the June 24, 1997 employment injury.

By letter dated May 8, 2009, the Office referred appellant to Dr. Timothy Nice, a Board-certified orthopedic surgeon, to resolve the conflict in medical opinion between Dr. Price and Dr. Furnich with regard to her continuing disability, residuals and capacity for work. In a May 28, 2009 report, Dr. Nice noted appellant's subjective complaints of having pain in her right tendon but stated that there was nothing on physical examination that established a dysfunctional tendon. He noted that, even if she did have a dysfunctional tendon, it would not necessarily cause pain but would cause a dysfunction in terms of her walking, running or climbing steps and stairs. There was nothing in appellant's file to indicate that she had any nerve injury with the abrasion/laceration she sustained. Dr. Nice noted that she came in wearing a regular shoe and not a protective device over the tendon or sock to protect the clothes from rubbing the skin on the back of her leg. Therefore, he was "suspect about how sensitive this area really is." From the standpoint of the accepted right leg abrasion/contusion and cellulitis, these pathologies had each healed and resolved. Dr. Nice opined that, based on appellant's allowed and accepted conditions, there was no long-term residuals that would prevent her from returning to the type of work she previously performed. He recommended a magnetic resonance imaging (MRI) scan of the Achilles tendon of the right leg and a visit to a qualified orthopedic surgeon to discuss further conservative modalities that might help her. Dr. Nice noted that another issue was whether appellant had any nerve pathology in that wound area and that could cause increased sensitivity

in her wound. He stated that this "should all be sorted out but that these conditions all set aside I think she certainly could return to a sedentary type of work working six to eight hours a day where she could alternatively sit, stand, walk, have breaks and limit her lifting to 20 to 40 pounds with intermittent bending and stooping with no squatting, kneeling or climbing." Dr. Nice noted that appellant had other medical conditions related to her general health that had nothing to do with the accepted injury including obesity, diabetes, chronic liver issues and arthritis in both knees.

In a July 30, 2009 report, Dr. Nice noted that, aside from a small scar, appellant had no significant residuals of the right leg abrasion, contusion, wound and her tendinitis symptoms had subsided. Appellant had a subsequent injury to her knee when she was pushed by another worker at Stouffer's in October 1997 and was treated by surgery in 1998 for a torn medical meniscus. She sustained another injury to her right knee when she was in an automobile accident and again underwent knee surgery in 2003. Dr. Nice found full plantar flexion and dorsiflexion of appellant's ankle and aside from hypersensitivity of the skin. There was no significant residual of the accepted tendinitis, abrasion or the contusion. Dr. Nice stated that the abrasion and contusion symptoms subsided within a two- to three-month period. He noted that appellant's operation on October 23, 2000 was not a formal repair but a debridement and, aside from hypersensitivity of the skin in the area where she had the original wound, there was no significant residual of the accepted conditions in terms of functional disability. Dr. Nice also discussed her medical history and stated that her back condition was unrelated to her employment injury. Based on her work-related conditions, appellant could perform her date-of-injury job; but the fact that she was unable to work was not based on the employment injury she sustained in 1997. Dr. Nice concluded that her ongoing right knee and back complaints were unrelated to her employment injury but due to low back pain and a small herniated disc at L5.

On September 2, 2009 the Office issued a notice of proposed termination of appellant's wage-loss compensation. It also proposed terminating medical benefits for her leg abrasion/contusion, single episode of right leg cellulitis and Achilles tendinitis. The Office kept appellant's claim open for medical treatment for hypersensitivity of the wound area around the incision for the Achilles tendon surgery. Appellant did not submit new evidence responding to the proposed termination.

By decision dated October 6, 2009, the Office finalized the termination of appellant's monetary and medical benefits.

On October 6, 2009 appellant requested a telephonic hearing.

In a July 9, 2009 note, Dr. Price stated that appellant was still having stabbing pains in her right Achilles tendon which was injured in 1997 with dysfunction. In a November 7, 2009 note, he stated that she still had stabbing pain in her right Achilles tendon. Upon examination, appellant's right ankle revealed that the Achilles tendon area remained quite swollen and tender compared to the left. She had pain upon dorsiflexion and plantar flexion of the ankle and foot. Although there was no active cellulitis or infection present, the right Achilles tendon area was much more swollen than the left with pain upon palpitation. Dr. Price advised that appellant remained disabled from the June 24, 1997 employment injury. He also noted that she had seen him once a month for the past three years for her injury and it was necessary for her claim to be

reopened. In a December 5, 2009 note, Dr. Price listed his impression as poor surgical repair of the right Achilles tendon. On December 19, 2009 he again noted appellant's complaint of severe pain in her right Achilles tendon and opined that she might need repeat surgery. Appellant continued to walk with a limp and stumbling antalgic gait. In a February 2, 2010 report, Dr. Price listed his impression as tear of the right Achilles tendon with inadequate surgical repair resulting in chronic pain and residual swelling.

In an October 14, 2009 report, Dr. Daniel Leizman, a Board-certified physiatrist, noted that appellant presented that date for follow up of injuries sustained to her right knee and right ankle in a work-related injury claim sustained on June 24, 1997. He assessed her with right infected abrasion or friction burn of the hip, thigh, leg and ankle, right contusion of knee and lower leg, right cellulitis or abscess of unspecified site, right open wound of knee, leg and ankle with tendon involvement and right knee Achilles bursitis. In a November 4, 2009 report, Dr. Leizman noted a right infected abrasion or friction burn of the hip, thigh, leg and ankle and recommended continued follow up with her primary care physician.

At the hearing held on February 18, 2010, appellant testified that she did not have problems with her right leg before her work injury. Following surgery did not feel better and was never pain-free. Appellant was given a boot to wear and physical therapy. She testified that she needed a cane to walk.

In a January 19, 2010 report, Dr. Patrick J. Getty, a Board-certified orthopedic surgeon, diagnosed posterior left ankle pain, status post report Achilles' tendon repair. In a February 4, 2010 report, he diagnosed right ankle pain and right ankle subcutaneous inflammation. Dr. Getty recommended a combination of both a boot to rest soft tissues and as a course of physical therapy for rehabilitation.

In a January 27, 2010 report, Dr. Peter Young, a Board-certified radiologist, interpreted an MRI scan of appellant's ankle as showing mild subcutaneous edema involving the medial and lateral ankle which is nonspecific. He also found no evidence of acute fracture or dislocation; however, he noted a thickening of the Achilles tendon consistent with tendinopathy and no partial or full-thickness tear.

In an April 12, 2010 report, Dr. Shana Miskovsky, a Board-certified orthopedic surgeon, stated that as the structure of appellant's foot and ankle was intact and that there was no tendon tear and no significant arthritic changes. Appellant's pain, which did not improve with rest or being off her foot, was more consistent with a neurologic type of problem, including a crush-type injury to the nerve that could result in chronic regional pain syndrome. Dr. Miskovsky noted that appellant was trying to avoid taking medication. She encouraged appellant to work with the anesthesia pain service. The only other option would be amputation of appellant's leg if the pain became severe and recalcitrant to therapy. Dr. Miskovsky noted that appellant had diffused tenderness to the lightest touch globally throughout the right lower extremity which was more consistent with a nerve crush sequela. She found that the Achilles tendon had healed and was repaired properly.

By decision dated May 6, 2010, the Office hearing representative affirmed the October 6, 2009.

LEGAL PRECEDENT

Once the Office accepts a claim, it has the burden of justifying termination or modification of compensation benefits.[2] It may not terminate compensation without establishing that the disability ceased or that it is no longer related to the employment.[3] Its burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[4] Furthermore, the right to medical benefits for an accepted condition is not limited to the period of entitlement for disability. To terminate authorization for medical treatment, the Office must establish that a claimant no longer has residuals of an employment-related condition that requires further medical treatment.[5]

Section 8123(a) of the Act provides in pertinent part: If there is a disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[6] In situation where there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficient well rationalized and based upon a proper factual background, must be given special weight.[7]

ANALYSIS

The Office accepted that appellant sustained a right leg contusion/laceration, tear of the Achilles tendon, tendinitis and right leg cellulitis as a result of the June 24, 1997 work injury. Appellant received wage-loss compensation for disability and medical benefits for ongoing treatment. She underwent surgery on October 23, 2000 to repair her right Achilles tendon. Appellant has not worked since the date of her surgery. Her treating physician, Dr. Price, found that she was totally disabled due to residuals of her employment-related injury. The second opinion physician, Dr. Furnich, found that appellant's residuals from her work-related injury resolved without further disability. Due to a conflict in medical opinion between her treating physician and the second opinion physician, the Office referred her to Dr. Nice for an impartial medical examination.

Dr. Nice conducted an extensive review of the medical evidence and a physical examination. Based on appellant's accepted work-related conditions, she could perform her date-of-injury job. Dr. Nice opined that her right leg abrasion/laceration and cellulitis had healed without residuals. Appellant had two subsequent injuries to her knee that were not related to her federal employment. Dr. Nice explained that her other medical conditions related to her general

[2] *I.J.*, 59 ECAB 408 (2008); *Fermin G. Olacoaga*, 13 ECAB 102, 104 (1961).

[3] *J.M.*, 58 ECAB 478 (2007); *Anna M. Blaine*, 26 ECAB 351 (1975).

[4] *T.P.*, 58 ECAB 524 (2007); *Larry Warner*, 43 ECAB 1027 (1992).

[5] *Mary A. Lowe*, 52 ECAB 223 (2001); *Wiley Richey*, 49 ECAB 166 (1997).

[6] 5 U.S.C. § 8123(a).

[7] *Jack R. Smith*, 41 ECAB 691, 701 (1990); *James P. Roberts*, 31 ECAB 1010, 1021 (1980).

health, her obesity, diabetes, chronic liver issues and arthritis to both knees and were unrelated to her work injury. Although appellant had subjective complaints of pain in her right tendon there was nothing on physical examination that established a dysfunctional tendon. Dr. Nice further noted that even if she did have a dysfunctional tendon it would not necessarily cause pain. He concluded that appellant was no longer disabled due to the accepted employment conditions. Dr. Nice noted that the only remaining injury that required further medical treatment was hypersensitivity of her skin in the area of the original wound. The Office properly gave special weight to the well-rationalized opinion of Dr. Nice, the impartial medical examiner and terminated appellant's compensation for wage-loss and medical benefits for the other remaining medical conditions.

The Board does not find that the evidence submitted before the Office hearing representative was sufficient to overcome the special weight of the medical opinion evidence given to the impartial medical examiner. The subsequent opinions of Dr. Price basically reiterate his opinion that appellant continued to have residuals and be disabled from the employment injury. The Board has long held that reports from a physician who was on one side of a medical conflict that an impartial specialist resolved are generally insufficient to overcome the weight accorded to the report of the impartial medical examiner or to create a new conflict.[8]

The Board also finds that the opinions of the remaining physicians are insufficient to overcome the weight of the impartial medical examiner. Dr. Leizman noted appellant's employment injury and assessed various injuries to her right leg. However, he never explained how these injuries were still related to the employment injury that occurred over 12 years prior to his report. Dr. Young interpreted appellant's MRI scan but rendered no opinion as to whether her subsequent conditions were disabling or required further medical treatment. Dr. Getty also reviewed the MRI scan but also did not provide an opinion as to how her current right ankle condition was causally related to the distant employment injury. Furthermore, he appears unaware that appellant had any subsequent injuries. Dr. Miskovsky does not attribute appellant's current conditions to her employment injury. The Board also notes that Dr. Miskovsky clearly indicates that appellant's Achilles tendon has healed as it was properly repaired. Accordingly, the Board finds that the Office properly terminated appellant's compensation benefits and all medical benefits except for treatment of hypersensitivity of the scar tissue.

CONCLUSION

The Board finds that the Office met its burden of proof to terminate appellant's compensation and certain medical benefits effective October 6, 2009.

[8] *I.J.*, 59 ECAB 408 (2008).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated May 6, 2010 is affirmed.

Issued: May 23, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board