United States Department of Labor
Employees' Compensation Appeals Board

P.B., Appellant	)	
and	)	**Docket No. 13-636**
DEPARTMENT OF THE TREASURY, BUREAU OF ENGRAVING & PRINTING, Fort Worth, TX, Employer	)	**Issued: November 14, 2013**

Appearances:
Tim E. Buchanan, for the representative
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On January 22, 2013 appellant, through her representative, filed a timely appeal from an August 30, 2012 merit decision of the Office of Workers' Compensation Programs (OWCP) terminating wage-loss compensation benefits and denying her claim for continuing employment-related disability. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are(1): whetherOWCP met its burden of proof to terminate appellant's wage-loss compensation effective October 3, 2004 on the grounds that she was no longer disabled due to the March 13, 2002 work injury; and (2) appellant established that she had any continuing employment-related disability after October 3, 2004 due to her accepted conditions.

[1] 5 U.S.C. §§ 8101-8193.

On appeal, appellant requests that her compensation be restored because her accepted conditions have worsened.

FACTUAL HISTORY

On May 31, 2000 appellant, then a 46-year-old printing plant worker, injured her right shoulder at work. OWCP accepted the claim for right shoulder bursitis; File No. xxxxxx019. Appellantdid not stop work. A July 14, 2000 whole body scan was normal. On July 20, 2000 Dr. Myron L. Glickfeld, an attending osteopath, advised that appellantcould return to regular duty on July 24, 2000. Appellant received no wage-loss compensation under this claim.

On March 13, 2002 appellant, then a currency controller, filed a claim for injuryto both knees, both elbows, her right hand, right side of the head, left big toe and low back that day when she fell to the concrete floor. She stopped work that day. The claim was accepted for left knee sprain, derangement of the lateral meniscus of the left knee, herniated disc at L4-5 level with disc disease and spondylosis; File No. xxxxxx681.

A job description indicated that the currency controller position was a data entry position, working at a computer. The required sitting, standing, lifting up to eight pounds and walking, with constant use of hands, arms, fingers, wrist and eyes.

Dr. Clarence J. Brooks, an attending family physician, began treating appellant on March 14, 2002 and found that she was totally disabled. An April 2, 2002 magnetic resonance imaging (MRI) scan of the lumbar spine demonstrated degenerative disc disease and a herniation at L4-5. An April 2, 2002 left knee MRI scan showed minimal joint effusion and degeneration of the medial and lateral meniscus without evidence of tear. The collateral ligaments and cruciate and patellar tendons were intact and unremarkable. On October 9, 2002 appellant underwent arthroscopic surgery on the left knee.

Dr. Brooks found that appellant could not return to work due to diagnosed left knee and lumbar conditions. Appellanthad decreased range of motion and back spasms, which would worsen with work.An April 18, 2003functional capacity evaluation (FCE) demonstrated that she could perform sedentary duties.Appellant began work hardening in April 2003 but did not complete the recommended program.

In June 2003, OWCP referred appellant for a second-opinion evaluation by Dr. Robert Chouteau, an osteopath and orthopedic surgeon. A July 15, 2003 FCE showed that she functioned at the sedentary physical demand level. In a July 15, 2003 report, Dr. Chouteau reviewed the medical record and the July 15, 2003 FCE. He provided findings on examination and diagnosed herniated disc at L4-5 with disc disease and spondylosis, left knee traumatic patellar chondromalacia and osteonecrosis of the medial femoral condyle. Dr. Chouteauadvised that appellant continued to have residuals of the accepted lumbar condition but could return to modified duties. Appellant could work for eight hours a day, with permanent restrictions including a 10-pound lifting restriction.

In letters dated August 12 and November 13, 2003, OWCP forwarded Dr. Chouteau's report to Dr. Brooks. It asked that he respond to specific questions regarding Dr. Chouteau's assessment. Dr. Brooks did not respond.

A January 12, 2004 electrodiagnostic study was consistent with bilateral L5 radiculopathy.[2]

OWCP found a conflict in medical opinion between Dr. Brooks and Dr. Chouteau regarding appellant's disability and work capability. In January 2004,it referred her to Dr. David R. Willhoite, a Board-certified orthopedic surgeon, for an impartial medical examination. Questions posed by OWCP included whether appellant's accepted conditions had resolved and whether she had work restrictions attributable to her work injury. OWCP asked that Dr. Willhoite provide rationale to support all opinions.

In a February 23, 2004 report, Dr. Willhoite noted that a 1990 injury had resolved. He discussed the history of the March 13, 2002 employment injury, appellant's medical history and her complaints of intermittent knee pain and swelling with occasional give-way and occasional low back pain and stiffness that increased with prolonged sitting or standing. Dr. Willhoite indicated that on physical examination she had a normal gait and some complaints of tenderness in the lumbar region. Sitting straight-leg raising was negative and supine produced low back pain. Motor and sensory examinations of the lower extremities were normal. Examination of the left knee demonstrated mild tenderness and crepitus with no swelling. Dr. Willhoite diagnosed postoperative arthroscopic surgery, left knee, with mild chondromalacia of the patella and herniated disc at L4-5. He advised that appellant continued to have residuals of the herniated disc at L4-5 and that he felt she could do sedentary work. Dr. Willhoite continued that he felt that shehad most likely reached maximum medical improvement. He indicated that appellant should change positions frequently and provided temporary restrictions for six to eight months of no climbing, crawling, bending, stooping or kneeling; walking for three hours; standing, reaching and reaching above the shoulder for two hours; and lifting restricted to 10 pounds. Dr. Willhoite concluded that she was not a surgical candidate and would continue to need anti-inflammatory and mild pain medication.

Dr. Brooks referred appellant to Dr. Leighton B. Parker, a Board-certified neurosurgeon, who saw her on February 25, 2004. He advised that neurological examination was normal and that MRI scan studies of the cervical and lumbar spine did not reveal any evidence of ruptured discs or significant thecal sac or nerve root compression or stenosis. Dr. Parker stated that he informed appellant that he saw no reason for any form of neurosurgical intervention in the lumbar or cervical spine. Dr. Brooks then referred her to Dr. Jacob Rosenstein, a Board-certified neurosurgeon. In an April 12, 2004 report, Dr. Rosenstein performed neurological examination and diagnosed low back pain with occasional right leg pain and right lumbar radiculopathy. He recommended a lumbar myelogram to determine if appellant had significant nerve root compression. An April 30, 2004 lumbar myelogram with computerized tomographyscan of the lumbar spine demonstrated mild disc bulging at L3-4, L4-5 and L5-S1 with no disc herniations

[2] Appellant was removed from the employing establishment effective February 14, 2004 due to prolonged absence from work.

or spinal stenosis identified. In a May 12, 2004 report, Dr. Rosenstein reviewed the April 30, 2004 myelogram. He indicated that appellant wanted to proceed with further physical therapy.

OWCP subsequently provided Dr. Willhoite with appellant's position description and asked that he address her ability to perform her date-of-injury job.In a June 9, 2004 report, Dr. Willhoite noted that he had reviewed her job description and opined that she should be able to perform the duties of a currency controller.

On August 11, 2004 OWCP proposed to terminate appellant's wage-loss compensation on the grounds that the medical evidence established that the employment injury no longer prevented her from returning to the date-of-injury job as a currency controller. Appellant disagreed with the proposed termination.

By decision dated September 20, 2004, OWCP found that the weight of the medical evidence rested with the opinion of Dr. Willhoite who performed the referee examination and finalized the termination of wage-loss compensation, effective October 3, 2004. Medical benefits were not terminated.

On October 11, 2004 appellant requested reconsideration and submitted reports dated September 1 and October 12, 2004,from Dr. Rosenstein who reiterated his opening. She was also scheduled for lumbar facet injections. In a September 29, 2004 report, Dr. Brooks advised that appellant remained totally disabled due to the employment injury. On October 11, 2004 he advised that he agreed with Dr. Chouteau's assessment.

In a merit decision dated October 27, 2004, OWCP denied modification of the September 20, 2004 decision.

On November 29, 2004 appellant requested reconsideration and submitted additional medical evidence. In an October 13, 2004 report, Dr. Rosenstein provided physical examination findings, diagnosed low back pain, right lumbar radiculopathy, lumbar facet syndrome and mild disc bulging at L3-4 and L4-5. He performed lumbar facet injections on October 18, 2004. In treatment notes dated November 4 and 22, 2004, Dr. Brooks reiterated his findings and conclusions. In November 22, 2004 correspondence, he noted his review of Dr. Willhoite's report. Dr. Brooks advised that appellant was under the care of Dr. Rosenstein and having lumbar injections and opined that, if Dr. Rosenstein agreed, she could return to restricted duty, to begin part-time and progress to full-time work. On November 30, 2004 Dr. Rosenstein recommended physical therapy and advised that she could return to modified duty with no lifting greater than 10 pounds and limit bending of the waist to 30 degrees.In a disability slip dated December 8, 2004, Dr. Brooks indicated that appellant had been under his care from March 13, 2002 to January 3, 2005 and was totally incapacitated. He advised that she could return to restricted duty on January 4, 2005 with the restrictions provided by Dr. Rosenstein.

In a merit decision dated February 14, 2005, OWCP denied modification of the previous decisions on the grounds that the medical evidence did not support an inability to work.

On September 30, 2005 appellant requested reconsideration of the February 14, 2005 decision, asking that her monetary benefits be reinstated. In treatment notes dated April 22 to September 29, 2005, Dr. Brooks noted that she was seen for routine check-ups and continued to

complain of neck, back and knee pain. In an April 26, 2005 report, Dr. Rosenstein reiterated his opinion. He performed a lumbar injection on May 26, 2005 and appellantwas seen in followup on July 26, 2005. On January 10, 2006 Dr. Brooks advised that she was able to resume work without restrictions.

In a merit decision dated March 17, 2006, OWCP denied modification of its previous decisions. On September 11, 2006 it combined appellant's OWCP File No. xxxxxx019, for the May 31, 2000 right shoulder injury, with the instant claim, adjudicated under OWCP File No. xxxxxx681.

In a request datedMarch 16, 2007 and postmarked March 19, 2007, appellant's attorney requested reconsideration. In a January 24, 2007 report, Dr. Tom G. Mayer, a Board-certified orthopedic surgeon, noted the history of injury in 2002 and indicated that appellant currently worked part time as a hospital admitting clerk. He reviewed some of her medical records and disagreed with Dr. Willhoite's conclusion that she could perform the duties of currency controller. Dr. Mayer noted that appellant had intense pain, made worse by walking, bending, squatting, kneeling and climbing which limited her activities of daily living. He provided examination findings of low back tenderness and an equivocal straight leg raising test and knee tenderness, no significant effusion, a positive compression test, stable ligaments and a negative meniscal compression test. Dr. Mayerdiagnosed: chronic right lumbar radicular pain; electrodiagnostic test findings of right L5 radiculopathy; imaging findings of degenerative disc disease at L3 to S1 and a herniated disc at L4; chronic left knee pain with moderate patellofemoral dysfunction; intermittent cervical pain; severe persistent conditioning syndrome; and chronic pain syndrome with medical/psychological features. Headvised that appellant had not reached maximum medical improvement and recommended an FCE. In an e-mail sent to appellant's attorney on January 30, 2007Dr. Mayeradvised that she remained totally disabled due to inappropriate medical care.

In an April 24, 2007decision, OWCP found that appellant did not present clear evidence of error on the part of OWCP and denied the reconsideration request. On April 24, 2007 appellant appealed the April 24, 2007 decision to the Board. In an order dated March 13, 2008, the Board remanded the case to OWCP. The Board noted that, even though the time period for filing a request for reconsideration would ordinarily end on March 17, 2007, since that date was a Saturday, the deadline for filing a request for reconsideration extended to the close of business on Monday, March 19, 2007, the next business day after the expiration of the one-year period. Appellant's reconsideration request to OWCP was postmarked on March 19, 2007. On remand, OWCP was to review of the evidence under the proper standard of review for a timely request for reconsideration.[3]

By decision dated July 25, 2008, OWCP considered the merits of appellant's claim and denied modification of the prior decisions.

On July 12, 2009 appellant, through her attorney, requested reconsideration and submitted a September 12, 2008 report in which Dr. Mayer reiterated her complaints of radiating low back and left knee pain. Dr. Mayer provided physical examination findings and reiterated

[3] Docket No. 07-2013 (issued March 13, 2008).

his diagnoses. He again noted that appellant was working parttime in a sedentary clerical position and repeated his disagreement with Dr. Willhoite's opinion. In October 23, 2008 correspondence, Dr. Mayer indicated that he had reviewed the evidence he had regarding her injury and opined that the preponderance of evidence suggested that it was more likely than not that her March 13, 2002 injury caused or precipitated her subsequent disability. In a January 22, 2009 report, Dr. Les Benson, who practices occupational medicine, noted the history of injury. He provided examination findings and diagnosed lumbar intervertebral disc, left knee internal derangement and chronic pain due to trauma. Dr. Benson opined, with reasonable medical certainty, thatthe injuries arose out of and in the course of appellant's job duties while working as a currency controller.

In a merit decision dated January 14, 2010, OWCP denied modification of the prior decisions. On May 5, 2010 it denied appellant's schedule award claim because the medical evidence did not establish that she was at maximum medical improvement.

On January 14, 2011 appellant requested reconsideration. By letter dated January 25, 2011, OWCP asked her to identify the decision she was asking OWCP to reconsider. An August 25, 2010 MRI scan study of the lumbar spine demonstrated diffuse bulges at L4-5 and L5-S1, a mild disc bulge at L3-4 and mild generalized facet arthropathy. An August 25, 2010 MRI scan study of the left knee showeda grade 2 signal in the body and posterior horn of the medial meniscus, degeneration in the anterior horn of the medial meniscus and both horns of the lateral meniscus, sprain of the anterior cruciate and medial collateral ligaments, mild changes of osteoarthritis, minimal synovial effusion, grade 1 chondromalacia patellae and mild subcutaneous edema around the knee joint. An MRI scan of the thoracic spine that day demonstrated a possible atypical hemangioma in T8. In August 16, 2010 and August 9, 2011 reports, Dr. Benson reiterated his previous findings and conclusions and opined that appellant now had a major depressive disorder and pain disorder associated with her medical condition. Appellant began psychological counseling with Larry G. Washington, M.S., on November 16, 2010. Mr. Washington performed psychological testing and diagnosed major depression, recurrent, moderate; chronic pain disorder; degenerative lumbar disease; lower extremity pain; occupational problems; and family and social life disturbance. In a December 2, 2010 report, Dr. Mike Shah, a Board-certified physiatrist, noted the history of injury and appellant's complaints of back, left knee and right shoulder pain. He advised that electrodiagnostic testing of the lower extremities was abnormal with evidence of chronic bilateral L5-S1 radiculopathies. A December 21, 2010 MRI scan study of the right shoulder demonstrated a SLAP 1 tear of the superior labrum, subscapularis bursitis and a small tear of the infraspinatus distally.

On January 6, 2011 Dr. Shah provided an impairment evaluation in which he advised that appellant had 14 percent impairment of each leg and 7 percent impairment of the right arm. His report was reviewed by an OWCP medical adviser and on March 9, 2011 she was granted a schedule award for 14 percent impairment of the left lower extremity and 14 percent impairment the rightlower extremity.

Dr. Jeffrey H. Pinotti, a chiropractor, examined appellant on February 17, 2011 and diagnosed right disorder of bursae and tendons in shoulder; derangement of left lateral meniscus; lumbosacral spondylosis without myelopathy; degeneration of lumbar intervertebral disc; and

thoracic/lumbosacral radiculitis or neuritis.In a November 11, 2011 behavioral medicine consultation report, Dr. Wayne Benson asked that the accepted conditions include a consequential emotional condition.[4] He diagnosed pain disorder associated with psychological factors and general medical condition secondary to work injury and chronic pain syndrome. In reports dated April 2 and May 2, 2012, Dr. Francisco J. Batlle, a neurosurgeon, noted the history of injury and appellant's complaint of radiating low back pain and sharp left knee pain and weakness. He reviewed the August 25, 2010 MRI scan study and conducted a neurological examination. Dr. Batlle diagnosed a herniated disc at L5-S1, lumbar radiculopathy and lumbago and recommended surgery. A June 13, 2012 MRI scan of the lumbar spine demonstrated no disc herniation at any level with mild central spinal stenosis at L3-4 through L5-S1 levels caused by moderate degenerative disc disease.

In a merit decision dated August 30, 2012, OWCP denied modification of the prior decisions.

LEGAL PRECEDENT -- ISSUE 1

Once OWCP accepts a claim and pays compensation, it has the burden of justifying modification or termination of an employee's benefits. It may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.[5] OWCP's burden of proof in terminating compensation includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[6]

Section 8123(a) of FECA provides that if there is 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.[7] When the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[8]

ANALYSIS -- ISSUE 1

The Board finds that OWCP did not meet its burden of proof to terminate appellant's monetary compensation effective October 3, 2004. The report of the referee physician Dr. Willhoite, is couched in speculative terms and is therefore of diminished probative value.[9] The accepted conditions of the March 13, 2002 employment injury are left knee sprain,

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[4] The credentials of Dr. Wayne Benson could not be ascertained.

[5] *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[6] *Id.*

[7] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

[8] *Manuel Gill*, 52 ECAB 282 (2001).

[9] *Frank Luis Rembisz*, 52 ECAB 147 (2000) (Medical opinions based upon an incomplete history or which are speculative or equivocal in character have little probative value).

derangement of lateral meniscus of left knee and herniated disc at L4-5 level with disc disease and spondylosis. OWCP determined that a conflict in medical evidence was created between Dr. Brooks, an attending physician, and Dr. Chouteau, an OWCP referral physician, regarding appellant's work capabilities after the March 13, 2002 employment injury. It referred her to Dr. Willhoitefor an impartial evaluation.

In a February 23, 2004 report, Dr. Willhoite described the history of injury and appellant's complaint of left knee and low back pain. He described examination findings and diagnosed postoperative arthroscopic surgery, left knee, with mild chondromalacia of the patella and herniated disc at L4-5 and advised that she continued to have residuals of the herniated disc at L4-5. Dr. Willhoite stated that he felt that appellant could do sedentary work and continued that he felt that she had most likely reached maximum medical improvement. He indicated that she should change positions frequently and provided temporary restrictions for six to eight months of no climbing, crawling, bending, stooping or kneeling; walking for three hours; standing, reaching and reaching above the shoulder for two hours; and lifting restricted to 10 pounds. Dr. Willhoite concluded that appellant was not a surgical candidate and would continue to need anti-inflammatory and mild pain medication. In a supplementary report dated June 7, 2004,heindicated that he had reviewed her job description and advised that she could perform the duties of currency controller.

The Board finds that Dr. Willhoite's opinion does not adequately address the questions asked by OWCP. Dr. Willhoite did not provide sufficient medical rationale or state his opinion to a reasonable degree of medical certainty. Rather, he contended how he felt about certain aspects of the case and that appellant had most likely reached maximum medical improvement. Dr. Willhoite's response to OWCP's request that he review her position description was one sentence. The Board concludes that his opinion is not entitled to the special weight accorded an impartial medical examiner. OWCP therefore did not meet its burden of proof to terminate appellant's monetary compensation effective October 3, 2004.

In light of the Board's findings regarding Issue 1, Issue 2 is rendered moot.

CONCLUSION

The Board finds that OWCP did not meet its burden of proof to terminate appellant's wage-loss compensation effective October 3, 2004.

ORDER

IT IS HEREBY ORDERED THAT the August 30, 2012 decision of the Office of Workers' Compensation Programs is reversed.

Issued: November 14, 2013
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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