United States Department of Labor
Employees' Compensation Appeals Board

J.B., Appellant	)	
and	)	**Docket No. 13-810**
	)	**Issued: November 5, 2013**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTATION MEDICAL CENTER, Manchester, NH, Employer	)	

Appearances:
James G. Noucas, Jr., Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 5, 2013 appellant,through her attorney, filed a timely appeal from a January 9, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP). 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.

ISSUE

The issue is whether appellant established that shehad any continuing employment-related residuals after April 10, 2011 due to her accepted conditions.

On appeal, appellant's attorney asserts that OWCP did not meet its burden to terminate wage-loss and medical benefits effective April 10, 2011 because, as determined by an OWCP hearing representative on December 12, 2011, a conflict in medical evidence existed. The attorney further asserted that the subsequent referee report was deficient and not probative and

[1] 5 U.S.C. §§ 8101-8193.

that OWCP failed to consider appellant's two additional accepted injuries, which should have been combined with the instant case.

FACTUAL HISTORY

On February 23, 2006 appellant, then a part-time 56-year-old pharmacy technician, filed a traumatic injury claim, alleging that on February 21, 2006 she injured her knees, back and buttocks when she slipped on a wet floor and jammed into a wall. She stopped work on February 23, 2006. On April 10, 2006 appellant returned to part-time modified duty for 3.5 hours per week. On May 10, 2006OWCP accepted the claim for lumbar radiculopathy and aggravation of sacroiliac dysfunction. Appellant began working two 3.5-hour shifts in June 2006.[2]

The record reflects that appellant's regular work schedule was 22 hours a week, with an additional average of 9 hours of "on-call" duty, for a total work week of 31 hours. The employing establishment indicated that she worked seven hours per week in her pharmacy job and the remaining hours were for duties as a union official. Appellant received appropriate compensation, based on an average work week of 31 hours.

The record indicates that appellant had two additional accepted injuries. In a claim adjudicated under file number xxxxxx439, OWCP accepted that on December 18, 2002 she sustained a right knee strain. In a claim adjudicated under file number xxxxxx214, appellant sustained a bilateral medial meniscal tears, a left knee contusion, a right shoulder strain, a left cervical strainand a sacroiliac strain on August 22, 2003.[3] On November 5, 2003 file number xxxxxx439 was combined with file number xxxxxx214. The instant claim, adjudicated under file number xxxxxx249, was combined with the previous two files on March 1, 2006 with file number xxxxxx214 being the master file.

In an April 3, 2006 report, Dr. Stephen J. Dainesi, Board-certified in anesthesiology and pain medicine, diagnosed bilateral sacroiliac joint dysfunction with symptoms of lumbar radiculopathy. He indicated that a recent magnetic resonance imaging (MRI) scan study demonstrated degenerative disc disease at L2-3, L3-4 and L4-5 with a disc bulge at L2-3 and L3-4, no disc herniation and no spinal stenosis. On April 3, 2006 Dr. James C. Vailas, a Board-certified orthopedic surgeon, advised that appellant could return to modified duty for 3.5 hours, one day per week. Dr. David B. Lewis, an attending Board-certified physiatrist, provided duty status reports dated June 19, 2006 to March 31, 2008, in which he diagnosed right lumbar radiculopathy, lumbosacral and sacroiliac strains and sciatica. He advised that appellant could work two 3.5-hour shifts. On March 31, 2008 Dr. Lewis reported that she had progressively increasing low back pain with right foot numbness. He reiterated his diagnoses and work restrictions. On November 20, 2009 Dr. Lewis advised that appellant could not perform her usual job due to pain, spasm and weakness but could continue to work two 3.5-hour shifts weekly, longer as tolerated. He provided permanent physical restrictions and additionally

[2] The record is unclear when appellant began working two 3.5-hour shifts solely as union president but it does not appear that she returned to the pharmacy technician position after the 2006 employment injury.

[3] Appellant had surgery on the right knee on May 5, 2004 and left knee surgery on August 25, 2004.

diagnosed chronic knee pain. In reports dated December 22 and 28, 2009, Dr. Vailas diagnosed bilateral knee osteoarthritis and inflammatory arthropathy, traumatically induced. He advised that the restrictions provided by Dr. Lewis were permanent. Appellant continued to work part time and received appropriate compensation.

In reports dated November 11, 2010, Dr. Lewis diagnosed lumbar radiculopathy, disc displacement, sacroiliac dysfunction and multiple knee problems with increased pain and weakness. He indicated that appellant could work two 3.5-hourshifts weekly and provided permanent physical restrictions. In reports dated November 23, 2010, Dr. Vailas advised that she would need bilateral knee replacements in the future.

In December 2010, OWCP referred appellant to Dr. Richard L. Levy, a Board-certified neurologist, for a second opinion. The statement of accepted facts provided to Dr. Levy included a history of the three work injuries. In a January 3, 2011 report, he noted his review of the statement of accepted facts and medical record and appellant's description of the 2003 and 2006 employment injuries and her complaints of right foot tingling and sacroiliac pain. Physical examination demonstrated very good lumbar mobility, a negative straight leg raise and some subjective hypesthesia to touch on the sole of the left foot. Station and gait were normal and appellant had full ability to stand on her toes and heels. Dr. Levy diagnosed lumbar radiculopathy, probably at the left S1 level and noted that by history appellant had sacroiliac joint dysfunction. He indicated that appellant had reached maximum medical improvement and that her objective findings in the lumbar spine were degenerative and that degenerative disc disease and arthritis were the cause of her back and sacroiliac joint pain, which was not traumatically induced. Regarding work capabilities, Dr. Levy stated that shecould work seven hours of sedentary work per week, indicating that she could probably do more but that since this was what she had been working, seven hours weekly for four years, any attempt to increase her work capacity would probably fail. On an attached work capacity evaluation, he indicated that appellant could work in a sedentary job eight hours a day with walking and standing limited to two hours; rare twisting, bending, squatting, kneeling and climbing; and a five-pound weight restriction, with 10-minute breaks each hour. In a supplementary report dated January 27, 2011, Dr. Levy clarified that from an objective standpoint, she could work a full-time sedentary job, eight hours per day. He indicated that appellant had no residuals of the February 21, 2006 employment injury and that her symptoms were related to degenerative arthritis of the spine.

On February 10, 2011 OWCP proposed to terminate appellant's wage-loss compensation and medical benefits on the grounds that the medical evidence established that the February 21, 2006 employment injury had resolved with no residuals.

Appellant, through her attorney, disagreed with the proposed termination and submitted additional medical evidence. In a February 17, 2011 report, Dr. Lewis noted the 2003 and 2006 employment injuries and her medical condition and treatment. He noted that he had seen appellant multiple times over the years and that since the 2006 injury she had increased sacroiliac dysfunction and lumbar radiculopathy. Dr. Lewis indicated that she could continue to work two 3.5-hour shifts weekly and could work more if she felt she could tolerate it. In a February 24, 2011 report, Dr. Dainesi indicated that appellant had been followed in his pain clinic for many years. He stated that the August 2003 injury led to sacroiliac dysfunction and that,after the February 2006 injury, appellant suffered lumbar radiculopathy and aggravation of

sacroiliac dysfunction. Dr. Dainesi noted that she had electrodiagnostic findings of L3-4 neuropathy and described her pain treatment regimen. He opined that appellant's continuing severe sacroiliac dysfunction, intermittent lumbar radiculopathy and painwere due to the employment injuries and these limited her ability to work fulltime.

By decision dated March 22, 2011, OWCP found that the weight of the medical evidence rested with the opinion of Dr. Levy, an OWCP referral physician and finalized the termination of wage-loss compensation and medical benefits, effective April 10, 2011.

Appellant timely requested a hearing that was held on August 11, 2011. At the hearing she indicated that around 1985 she began working 31 hours a week. Appellant described the 2006 employment injury, stating that she slipped and did not fall but jammed into a wall. In a September 9, 2011 letter, Dr. Lewis indicated that, although she injured her back at work in 2003, it was only after the February 21, 2006 injury that she had more extensive complaints, especially in her leg which showed decreased reflex. He noted the MRI scan findings of multiple disc protrusions, advising that these correlated with her leg symptoms. Dr. Lewis opined that, even if appellant had degenerative disc disease prior to the 2006 injury, her symptoms were stable and it was only after the 2006 injury that she required further intervention. He stated that her sacroiliac dysfunction, caused by the 2003 employment injury, was a different diagnosis and problem, but was related to the lumbar radiculopathy and was also worsened by the 2006 employment injury. Dr. Lewis discussed Dr. Levy's report and indicated that, because of appellant's multiple issues, it was difficult for her to do extensive walking and standing, as required by her job.

In a December 19, 2011 decision, an OWCP hearing representative found that, while the termination decision was appropriate at the time it was issued, Dr. Lewis' September 9, 2011 report created a conflict in medical opinion evidence as to whether appellant continued to have residuals of the accepted conditions. The hearing representative affirmed in part and set aside in part the March 22, 2011 decision and remanded the case to OWCP for an impartial medical evaluation.

In January 2012, OWCP referred appellant to Dr. Jonathan W. Sobel, a Board-certified orthopedic surgeon, for an impartial evaluation. In correspondence dated March 16, 2012, it informed appellant's attorney that the 2006 injury, adjudicated under file number xxxxxx249, had been administratively combined with file number xxxxxx214.

In an April 24, 2012 report, Dr. Sobel noted his review of the medical record and statement of accepted facts and discussed the December 2002 and August 2003 employment injuries and treatment. He noted that appellant was working two 3.5-hour shifts per week in a sedentary capacity as union presidentand that she reported that her activities of daily living were very limited. Dr. Sobel indicated that appellant moved in and out of the examination room without problem, although she used her hands to rise from a seated position to standing and she transitioned to the examination table without problem, using a stepstool.Appellantwas able to do toe stands and heel raises. Lumbosacral spine range of motion was diminished. In a seated position, her lower extremities did not show evidence of fasciculations.Knee reflexes were 2+ and ankle reflexes were 1+. Dr. Sobel noted that it was quite difficult to elicit ankle reflexes until a double confusion test was done and that appellant had good range of motion of both

kneeswith normal alignment, no effusion and 1-2+ patellofemoral crepitation. Appellanthad moderately advanced atrophy of her quadriceps bilaterally and appeared to be relatively deconditioned which, Dr. Sobel opined, reflected many years of a sedentary lifestyle. Patrick's test and straight leg raising were negative bilaterally in the supine position. She had maximal discomfort to palpation overlying the left iliac crest, left sacroiliac joint and the presacral area at L5-S1 with a slightly increased fixed cervicothoracic kyphosis.In a seated position, upper extremity examination demonstrated 2+ deep tendon reflexes at the elbows, 1+ at the wrists and mild thenar and hypothenar atrophy and some prominence of the right first carpometacarpal. Shoulder examination demonstrated full range of motion in a seated position and appellant had good range of motion of her cervical spine.

Dr. Sobel advised that appellant's ongoing condition reflected relatively minor effects of aging and osteoarthritis and that she had minor elements of lumbosacral mechanical pain but that he could not verify substantive sacroiliac joint dysfunction, pelvic obliquity or positive tests for sacroiliac joint pain or instability. He indicated that appellant's muscular atrophy and deconditioning were secondary to a prolonged sedentary lifestyle. Dr. Sobel advised that she had no residual effects from the 2006 employment injury and that she had been overtreated with facet and sacroiliac joint injections and ablations, which were unnecessary relative to either her arthritic condition or as a result of the claimed traumatic injury. He further advised that she had no ongoing residuals in regard to her lumbosacral spine with regard to the 2002 or 2003 employment injuries and that her ongoing condition reasonably reflected her age and the diagnosed degenerative conditions,which included osteoarthritis and degenerative disc disease. Dr. Sobel advised that appellant did not need further testing or treatment as a result of her employment injuries and that she could perform full-time sedentary work. He stated that he agreed with Dr. Levy's assessment, noting that her neurologic examination that day failed to reveal significant neurologic loss consistent with ongoing radiculopathy and that her subjectively reported symptoms reflected degenerative disc disease and referred lumbar pain with no evidence to suggest radiculopathy or positive root tension signs. Dr. Sobel concluded that the opinions in his report were based upon reasonable medical probability.

In a July 5, 2012 decision, OWCP denied modification of the March 22, 2011 decision, finding that the weight of the medical evidence rested with the opinion of Dr. Sobel who concluded that appellant had no residuals of the 2006 employment injury.

Appellant, through her attorney, timely requested a hearing, that was held on November 26, 2012. Her attorney stated that she had additional accepted claims, indicating that sacroiliac dysfunction was an accepted condition. Appellant testified that at most she worked 31 hours a week as a pharmacy technician and that, after the 2003 employment injury, she worked 31 hours a week as the union president and had not worked as a pharmacy technician in years. She described the 2002 and 2003 injuries and testified that she has many physical limitations and cannot sit, stand or walk in a prolonged fashion. Appellant stated that, at the time of Dr. Sobel's examination, she had just taken Percocet and she cannot travel for work more than twice a week.

In a November 19, 2012 report, Dr. Lewis provided examination findings and diagnosed lumbar strain, sacroiliac region strain, herniated lumbar disc and lumbar radiculopathy. He advised that appellant could continue to work two 3.5-hour shifts each week. On December 3, 2012 Dr. Lewis noted that he had treated her for many years and indicated that her case was

complicated. He stated that, after the 2003 employment injury, which required knee surgery, he became involved in her care for lumbosacral and sacroiliac dysfunction and that, although appellant did not have full resolution, she was able to return to work at her previous schedule but that, after the February 2006 work injury, her previous complaints worsened and she had increased symptoms involving her legs. Dr. Lewis stated that she had lost her right knee reflex when he examined her in June 2006, after the February 2006 injury and this was indicative of radiculopathy/sciatica and that MRI scan testing demonstrated disc protrusions at multiple levels and electrodiagnostic studies showed evidence of mild neuropathy at right L3-4. He opined that these complaints and findings were unique and only occurred after the February 2006 injury. Dr. Lewis stated that, although he disagreed with some of Dr. Levy's conclusions, his examination also showed an unobtainable reflex at the right knee and, contrary to Dr. Sobel's evaluation, except for a mild reflex at the left knee, he had never been able to obtain a right knee reflex after the 2006 injury, which made him question Dr. Sobel's clinical examination. He stated that while appellant was certainly not at 100 percent before the 2006 work injury, clearly this event caused a significant increase in her condition that required further treatment afterwards, opining that it caused increased stresses necessitating increased treatment that continued.

By decision dated January 9, 2013, an OWCP hearing representative affirmed the July 5, 2012 decision. He found that, as Dr. Sobel provided a comprehensive and convincing report, his opinion was entitled to the weight of the medical evidence.

LEGAL PRECEDENT

As OWCP met its burden of proof to terminate appellant's compensation benefits effective April 10, 2011, the burden shifted to her to establish that she had any continuing disability causally related to her accepted right upper extremity injury.[4] To establish a causal relationship between the condition, as well as any attendant disability claimed and the employment injury, an employee must submit rationalized medical evidence, based on a complete factual and medical background, supporting such a causal relationship.[5] Causal relationship is a medical issue. 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.[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

[4] *See Joseph A. Brown, Jr.*, 55 ECAB 542 (2004).

[5] *Jennifer Atkerson*, 55 ECAB 317 (2004).

[6] *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

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

specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[8]

ANALYSIS

The Board finds that appellant did not meet her burden of proof to establish any continuing disability after April 10, 2011 due to the accepted lumbar radiculopathy and aggravation of sacroiliac dysfunction. Contrary to appellant's assertion on appeal that the hearing representative found a conflict in medical evidence regarding the termination of compensation benefits in the December 19, 2011 decision, in that decision the hearing representative found that the termination decision was appropriate at the time it was issued. The hearing representativefound, however, that Dr. Lewis' September 9, 2011 report created a conflict in medical opinion evidence as to whether appellant continued to have residuals of the accepted conditions and affirmed in part and set aside in part the March 22, 2011 decision. She remanded the case to OWCP for an impartial evaluation on the issue of whether she had continuing employment-related disability. Appellant did not file an appeal from the December 19, 2011 decision with the Board.[9]

As to appellant's assertion on appeal that her cases should be combined, as noted above, the record indicates that on November 5, 2003, file numberxxxxx429 was combined with file number xxxxxx214, with the latter becoming the master file. The instant claim, adjudicated under file number xxxxxx249, was combined with the previous two files on March 1, 2006. Moreover, in correspondence dated March 16, 2012, OWCP informed appellant's attorney that the 2006 injury, adjudicated under file number xxxxxx249, had been administratively combined with file number xxxxxx214, with the 214 case becoming the master file.

By her hearing testimony, appellant testified that after the 2003 employment injury she worked 31 hours a week in a sedentary position as union president and had she had not worked as a pharmacy technician for years. She stated that since the 2006 injury she had solely worked as union president for two 3.5-hour shifts weekly.

In a comprehensive report dated April 24, 2012, Dr. Sobel, the referee physician noted his review of the medical record and statement of accepted facts and discussed the December 2002 and August 2003 employment injuries and treatment. Heperformed a thorough physical examination and advised that appellant's ongoing condition reflected minor effects of aging and degenerativeosteoarthritis and degenerative disc disease, that she had minor elements of lumbosacral mechanical pain but that he could not verify substantive sacroiliac joint dysfunction, pelvic obliquity or positive tests for sacroiliac joint pain or instability. Dr. Sobel indicated that she had muscular atrophy and deconditioning secondary to a prolonged sedentary lifestyle and that she had no residual effects of the spine from the 2002, 2003 or 2006 employment injuries. He stated that appellant did not need further testing or treatment as a result of her employment injuries and could perform full-time sedentary work. Dr. Sobel indicated that

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

[9] For final adverse OWCP decisions issued on and after November 19, 2008, a claimant has 180 days to file an appeal with the Board. *See* 20 C.F.R. § 501.3(e); *D.G.*, Docket No.12-770 (issued April 20, 2012).

he agreed with Dr. Levy's assessment, noting that her neurologic examination that day failed to reveal significant neurologic loss consistent with ongoing radiculopathy and that her subjectively reported symptoms reflected degenerative disc disease and referred lumbar pain with no evidence to suggest radiculopathy or positive root tension signs. He concluded that the opinions in his report were based upon reasonable medical probability.

In reports dated November 19 and December 13, 2012, Dr. Lewis noted that he had treated appellant for many years, stating that he became involved in her care for lumbosacral and sacroiliac dysfunction and that, after the February 2006 employment injury, her previous complaints worsened and she had increased symptoms involving her legs. He indicated that her case was complicated and advised that she could continue to work two 3.5-hour shifts each week. Dr. Lewisdescribed objective findings of multiple lumbar disc protrusions seen on MRI scan studies and electrodiagnostic evidence of mild right neuropathy. He questioned Dr. Sobel's clinical examination, because he found a mild knee reflex on the left, which Dr. Lewis could not find. Dr. Lewis concluded that, while appellant was certainly not at 100 percent before the 2006 employment injury, this event caused a significant increase in her condition that required further treatment afterwards, opining that it caused increased stresses necessitating increased treatment that continued.

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.[10] Dr. Lewis had been on one side of the conflict resolved by Dr. Sobel. Permanent aggravation of sacroiliac dysfunction has not been accepted as employment related and Dr. Lewis did not sufficiently explain how the 2006 injury, when appellant slipped and jammed into a wall, caused her current diagnosed conditions and symptoms such that she could not work 31 hours of sedentary work weekly. Regarding his questioningof Dr. Sobel's reflex findings, Dr. Sobel advised that he had difficulty eliciting ankle reflexes until a double confusion test was done.

The Board finds that Dr. Sobel provided a comprehensive, well-rationalized opinion in which he clearly advised that, within reasonable medical probability, any residuals of appellant's accepted conditions due to the February 21, 2006 employment injury had resolved and no longer caused work-related disability. Dr. Sobel's opinion is therefore entitled to the special weight accorded an impartial examiner and constitutes the weight of the medical evidence.[11] OWCP therefore properly terminated appellant's monetary compensation effective April 10, 2011.[12]

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

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

[11] *See Sharyn D. Bannick*, 54 ECAB 537 (2003).

[12] *Manuel Gill, supra* note 8.

CONCLUSION

The Board finds that appellant did not establish that she had any continued employment-related disability or condition after April 10, 2011 causally related to the February 21, 2006 employment injury.[13]

ORDER

IT IS HEREBY ORDERED THAT the January 9, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 5, 2013
Washington, DC

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

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

[13] The Board notes that appellant continues to receive medical benefits for her accepted knee conditions. There is no probative evidence that she is unable to perform the duties of a sedentary position due to the knee condition. In a January 16, 2007 report, Dr. Vailas noted treating appellant for bilateral knee pain. He indicated that Dr. Lewis had put appellant on permanent restrictions, which were more restrictive than for her bilateral knee osteoarthritis. Dr. Vailas continued to submit reports through November 23, 2010, when he referred appellant to an associate, Dr. Kathleen Hogan, also a Board-certified orthopedist. In an August 26, 2011 report, Dr. Hogan diagnosed knee arthritis and indicated that appellant could continue to work with the same restrictions. She reiterated this opinion on March 2, 2012. On October 16, 2012 Dr. Hogan indicated that she would not change appellant's work restrictions and recommended knee replacement surgery on the right.