# United States Department of Labor
# Employees' Compensation Appeals Board

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| **L.H., Appellant** | ) | |
| **and** | ) | **Docket No. 17-0552** |
| | ) | **Issued: July 5, 2017** |
| **DEPARTMENT OF THE INTERIOR, NATIONAL PARK SERVICE, GRAND TETON NATIONAL PARK, Moose, WY, Employer** | ) | |

*Appearances:*
*Appellant, pro se*
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

### ***JURISDICTION***

On January 11, 2017 appellant filed a timely appeal from a December 22, 2016 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 to consider the merits of the case.

### ***ISSUE***

The issue is whether OWCP met its burden of proof to terminate appellant's wage-loss compensation, effective December 21, 2016.

### ***FACTUAL HISTORY***

On March 26, 2014 appellant, then a 59-year-old laborer filed a traumatic injury claim (Form CA-1) alleging that he injured his right ankle while walking in the performance of duty on

[1] 5 U.S.C. § 8101 *et seq.*

March 25, 2014. He alleged that his right foot slipped out from under him and he developed a lump on his right ankle which hurt when walking. On May 29, 2014 OWCP accepted appellant's claim for right ankle sprain. It authorized wage-loss compensation benefits beginning May 27, 2014. On July 17, 2014 appellant's attending physician, Dr. Heidi E. Jost, an orthopedic surgeon, released him to return to light-duty sedentary work. However, the employing establishment did not have a sedentary position available for appellant in July 2014.

On June 18, 2014 appellant underwent a right ankle magnetic resonance imaging (MRI) scan which showed moderate tendinosis in the distal posterior tibial tendon at the navicular insertion, mild-to-moderate tendinosis in the peroneus longus, and mild-to-moderate osteoarthritis and thickening of the proximal plantar aponeurosis without acute edema, suggesting chronic degenerative change. Dr. Jost examined appellant on June 18, 2014 and noted that he had increased pain in the medial ankle/hindfoot, as well as increased pain on the lateral ankle. She prescribed a right lumbar sympathetic block for right lower extremity complex regional pain syndrome on August 25, 2014.

Dr. Charles L. Saltzman, a Board-certified orthopedic surgeon, examined appellant on October 15, 2014 and diagnosed a fracture of his navicular bone. An October 29, 2014 MRI scan exhibited nonspecific etiology, possibly reflex sympathetic dystrophy, but no evidence of bone bruise or separation of the articular relationship. In a November 12, 2014 note, Dr. Saltzman found that appellant was exquisitely tender to palpation at the posterior tibial tendon insertion on the navicular, but had sensation intact to light touch throughout his right foot. He reviewed the October 29, 2014 MRI scan and found posterior tibial tendon split tear as well as degeneration of the distal aspect of the posterior tibial tendon as it inserts at the navicular. Dr. Saltzman opined, "His history, symptoms, clinical examination, and MRI [scan] findings are all consistent with a posterior tibialis tendon tear occurring during a twisting injury in March 2014 that has failed to improve with conservative measures…."

On November 14, 2014 OWCP accepted rupture of tendons of the right foot and ankle as causally related to the March 25, 2014 employment injury. On December 2, 2014 Dr. Saltzman performed an authorized modified Kidner procedure due to partial posterior tendon tear and tendinosis at the level of the insertion of the posterior tibial tendon. He examined appellant on January 14, 2015 and found that he was recovering from his surgery. Dr. Saltzman found that appellant was neurovasculary intact and could return to work in eight weeks. On February 25, 2015 he released appellant to return to modified duty on that date with desk work only.

In a report dated March 16, 2015, Dr. Mark Bromberg, a Board-certified neurologist and clinical neurophysiologist, first examined appellant due to bilateral foot discomfort with pain on the soles of his feet to touch, discomfort during walking and spontaneous pain at night. He noted that appellant had previously sought treatment for tension headaches on April 15, 2014 from a colleague. Dr. Bromberg described appellant's history of injury in March 2014 and surgery in December 2014. On physical examination he found varicosities, joint position errors, and sensation errors. Dr. Bromberg diagnosed diabetic neuropathy based on laboratory findings.

OWCP referred appellant and a statement of accepted facts for a second opinion evaluation with Dr. Lowell M. Anderson, a Board-certified orthopedic surgeon, on March 20, 2015. In his April 8, 2015 report, Dr. Anderson performed a physical examination

and found right foot and ankle pain with prolonged weight bearing as well as bilateral foot symptoms including swelling, burning pain, and numbness in a stocking distribution. He noted that appellant's bilateral lower extremity varicose veins had been symptomatic for many years and caused ongoing swelling in his feet and ankles. Dr. Anderson also reported that appellant's bilateral foot and ankle numbness had been present over an extended time. He diagnosed bilateral lower extremity peripheral neuropathy, and bilateral lower extremity venous varicosities. Dr. Anderson found that appellant had continuing residuals of his accepted conditions which rendered him partially disabled including mild right ankle and foot swelling. Dr. Saltzman agreed with Dr. Anderson that appellant was capable of light-duty work on April 28, 2015.

In a note dated April 29, 2015, Dr. Saltzman found that appellant was doing well, except for peripheral neuropathy. He reported profusely decreased sensation of the feet and discoloration of his feet consistent with his peripheral neuropathy. Dr. Saltzman found that this condition was "idiopathic in nature" and continuing to affect appellant's ability to perform full duty.

As the employing establishment was unable to provide light-duty work for appellant, OWCP referred him for vocational rehabilitation services. On January 20, 2016 the employing establishment proposed to remove appellant from his date-of-injury position. In a March 3, 2016 letter, it notified appellant that his separation from employment would be effective March 11, 2016. The vocational rehabilitation counselor developed a training plan for appellant on July 8, 2016.

OWCP referred appellant for a second opinion evaluation on August 4, 2016 with Dr. Robert Lee, a Board-certified orthopedic surgeon.

Dr. Brigham B. Redd, a Board-certified orthopedic surgeon, examined appellant on August 9, 2016 due to left shoulder surgery which occurred July 14, 2016. Due to appellant's shoulder condition, his vocational rehabilitation plan was interrupted.

Dr. Lee completed a report on August 22, 2016 and reviewed the medical records. He noted that appellant recovered well following his surgery and could walk up to one mile a day. Dr. Lee performed a physical examination and found that appellant's right and left feet were similar in appearance, range of motion, and ankle stability. He found no pain with resisted inversion, eversion, plantar flexion, or dorsiflexion of either ankle. Dr. Lee particularly noted that there was no pain to palpation over the posterior tibialis tendon or the peroneal tendon of the right foot and ankle.

Appellant reported burning pain to both feet, and numbness in a stocking distribution to both feet and ankles. Dr. Lee noted that Dr. Bromberg had opined that appellant's ankle and foot conditions were consistent with diabetic neuropathy and metabolic syndrome. He noted decreased sensation in a stocking distribution with position errors of the toes and light touch errors throughout both feet. Dr. Lee opined that appellant had a successful repair of posterior tibialis tendon injury to the right foot and ankle with no symptoms or signs of right posterior tibialis tendon dysfunction. He also diagnosed continued symptomatic bilateral lower extremity peripheral neuropathy, "most likely secondary to diabetic neuropathy or metabolic syndrome."

Dr. Lee concluded, "This peripheral neuropathy does not appear to be related to the injury of March 25, 2014." He found that appellant was not capable of performing his date-of-injury position, but that his disability was not causally related to the accepted work injury. Dr. Lee opined that appellant's disability was due to his preexisting bilateral lower extremity varicose veins and peripheral neuropathy.

In a letter dated September 22, 2016, OWCP proposed to terminate appellant's wage-loss compensation benefits as Dr. Lee opined that appellant's current symptoms were due to nonemployment-related peripheral neuropathy. It found that Dr. Lee's report was entitled to the weight of the medical evidence.

In a report dated October 24, 2016, Dr. Reed I. Ward, an osteopath, noted appellant's history of employment injury, medical treatment, and diagnosis of neuropathy. He noted that appellant had significantly diminished light-touch perception on the right foot in a stocking-like distribution. Dr. Ward opined that appellant's peripheral neuropathy was consistent with appellant's work-related injury and that condition had been present since appellant's 2014 employment injury. He concluded that appellant could work, but could not stand more than two hours at a time.

By decision dated December 22, 2016, OWCP terminated appellant's wage-loss compensation, effective December 21, 2016, finding that Dr. Lee's report represented the weight of the medical evidence of record.

## ***LEGAL PRECEDENT***

Once OWCP 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.[2] After it has determined that an employee has disability causally related to his or her federal employment, OWCP may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment.[3]

A medical report is of limited probative value on a given medical question if it is unsupported by medical rationale.[4] Medical rationale includes a physician's detailed opinion on the issue of whether these is a causal relationship between the claimant's diagnosed condition and the implicated employment activity. The opinion of the physician must be based on a complete factual and medical background of the claim, 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 specific employment activity or factors identified by the claimant.[5]

[2] *Mohamed Yunis*, 42 ECAB 325, 334 (1991).

[3] *Id.*

[4] *T.F.*, 58 ECAB 128 (2006).

[5] *A.D.*, 58 ECAB 149 (2006).

## ***ANALYSIS***

The Board finds that OWCP met its burden of proof to terminate appellant's wage-loss compensation benefits, effective December 21, 2016.

OWCP accepted that on March 25, 2014 appellant sustained a right ankle sprain and rupture of tendons of the right foot and ankle in the performance of duty. In terminating appellant's wage-loss benefits, it relied on the second opinion report of Dr. Lee who provided a history of injury, reviewed the medical records, and thoroughly described physical examination findings. Dr. Lee's August 22, 2016 report found that appellant had recovered from his surgery, noting no pain in the right ankle with resisted range of motion and specifically no pain to palpation over the posterior tibialis tendon or the peroneal tendon of the right foot and ankle. He concluded that appellant's accepted employment injuries of right ankle sprain and rupture of tendons of the right foot and ankle had resolved. While Dr. Lee found that appellant was not capable of returning to his date-of-injury position, he clearly attributed this disability to appellant's diagnosed peripheral neuropathy, rather than to his accepted employment injuries.

There is no medical evidence of record supporting that appellant has continued work-related disability to his accepted employment injuries of ankle sprain and rupture of tendons of the right foot and ankle. The Board finds that Dr. Lee's report is sufficient to meet OWCP's burden of proof to terminate appellant's wage-loss compensation benefits for these accepted conditions.

Appellant's physician, Dr. Ward, completed a report on October 24, 2016 which included appellant's history of employment injury, medical treatment, and diagnosis of neuropathy. He found that appellant had significantly diminished light-touch perception on the right foot in a stocking-like distribution. Dr. Ward concluded that appellant's peripheral neuropathy was consistent with appellant's work-related injury and that condition had been present since appellant's 2014 employment injury. He found that appellant could work, but could not stand more than two hours at a time due to this condition. Dr. Ward did not provide any explanation for his conclusion that appellant's peripheral neuropathy was due to his employment injury. He did not provide medical reasoning explaining how and why appellant's bilateral peripheral neuropathy would be causally related to an accepted right lower extremity injury. A medical opinion that states a conclusion, but does not offer any rationalized medical explanation regarding the cause of an employee's condition, is of limited probative value on the issue of causal relationship.[6] Moreover, as OWCP has not accepted neuropathy as employment related, appellant has the burden of proof to establish a causal relationship.[7] He has not done so in this case.

The Board finds that Dr. Ward's opinion is insufficient to establish an additional employment-related condition or to establish a conflict in medical evidence with the well-rationalized opinion of Dr. Lee.[8] Dr. Lee had full knowledge of the relevant facts and evaluated

[6] *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *A.D.*, 58 ECAB 149 (2006).

[7] *See Jaja K. Asaramo*, 55 ECAB 200, 204 (2004).

[8] *M.A.*, Docket No. 16-1687 (issued January 26, 2017).

the course of appellant's accepted conditions. His opinion was based on proper factual and medical history and his report contained a detailed summary of this history. Dr. Lee addressed the medical records to make his own examination findings to reach a reasoned conclusion regarding appellant's conditions.[9] His opinion is found to be probative evidence, reliable, and sufficient to justify OWCP's termination of benefits for the accepted conditions.[10]

## ***CONCLUSION***

The Board finds that OWCP met its burden of proof to terminate appellant's wage-loss compensation benefits effective December 21, 2016.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the December 22, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 5, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board

[9] *See Michael S. Mina*, 57 ECAB 379 (2006) (the opportunity for and thoroughness of the examination, the accuracy and completeness of the physician's knowledge of the facts and medical history, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion are facts which determine the weight to be given to each individual report).

[10] *Supra* note 8.