United States Department of Labor
Employees' Compensation Appeals Board

S.T., Appellant	)	
and	)	**Docket No. 17-1720**
	)	**Issued: April 23, 2018**
DEPARTMENT OF VETERANS AFFAIRS, HUNTINGTON MEDICAL CENTER, Huntington, WV, 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 August 3, 2017 appellant filed a timely appeal from a July 5, 2017 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 the case.

ISSUE

The issue is whether appellant met her burden of proof to establish a recurrence of disability on May 2, 2016 causally related to a June 12, 2005 employment injury.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

This case has previously been before the Board.[2] The facts and circumstances outlined in the Board's prior decisions are incorporated herein by reference. The facts relevant to this appeal are set forth below.

On June 12, 2005 appellant, then a 47-year-old nurse, tripped on a floor-mounted door stop and twisted her knee while in the performance of duty. OWCP accepted her claim for a left knee medial meniscus tear and medial collateral ligament sprain.

Dr. Allen Young, a Board-certified orthopedist, began treating appellant on July 8, 2005. He noted the work injury and diagnosed sprain of the knee and leg, dislocation of the patella, and left knee medial meniscus tear.[3] On October 19, 2005 Dr. Charles E. Giangarra, a Board-certified orthopedist, performed an authorized partial medial meniscectomy and chondroplasty of the left knee. He diagnosed torn medial meniscus and degenerative joint disease of the left knee. Appellant returned to light-duty work and received intermittent wage-loss compensation for periods that she did not work.

Dr. Young continued to treat appellant for left knee symptoms. On March 25, 2013 he noted that she was doing poorly. Appellant reported having aqua therapy twice a week. Dr. Young noted findings of obesity, a limp, and mild-to-moderate tenderness medially. He diagnosed left knee and leg sprain and left medial meniscus tear.

On April 18, 2013 appellant submitted a claim for compensation (Form CA-7), claiming 88.5 hours of compensation for the period July 5 to December 18, 2012. On May 31, 2013 OWCP denied her claim. On August 1, 2013 an OWCP hearing representative set aside the May 31, 2013 decision. The hearing representative instructed OWCP to refer appellant for a second opinion to determine the relationship between her current symptoms and the June 12, 2005 work injury, the need for aqua therapy, the need for surgery, and work restrictions due to the June 12, 2005 work injury.

OWCP referred appellant to Dr. E. Gregory Fisher, a Board-certified orthopedist. In a December 4, 2013 report, Dr. Fisher opined that the accepted conditions were no longer present and had resolved with appellant reaching maximum medical improvement in early 2006 after returning to work. He noted that seven years of aqua therapy was excessive and no more than 12 visits were indicated. In a work capacity evaluation (OWCP 5-c), Dr. Fisher noted that appellant could work full time subject to restrictions that were not related to the June 12, 2005 work injury.

Thereafter, on August 23, 2013, OWCP denied appellant's claim. A hearing representative affirmed OWCP's May 1, 2014 decision. Appellant appealed to the Board. In an April 9, 2015

[2] Docket No. 14-1643 (issued April 9, 2015).

[3] A July 1, 2005 left knee magnetic resonance imaging (MRI) scan revealed grade 2 medial collateral ligament sprain and possible small peripheral tear of the medial meniscus, and low grade chondromalacia patella.

decision, the Board affirmed a May 1, 2014 decision finding that appellant failed to establish her claim for compensation for intermittent disability from July 5 to December 18, 2012.[4]

Appellant was treated by Dr. Young from June 25 to October 19, 2015 for chronic left knee pain due to an injury at work. Right knee pain developed because she shifted most of her weight to the right side to accommodate for her abnormal left knee. Dr. Young indicated that appellant would need a left knee replacement. He continued regular duty at her desk job. On March 10, 2016 Dr. Young noted that appellant continued to have bilateral knee issues and reported having both knees replaced three months earlier. He diagnosed sprain of other parts of left knee and continued regular duty at her desk job.

On June 1, 2016 appellant filed a claim for compensation for leave without pay (LWOP) for total disability (Form CA-7) beginning May 2, 2016. In a letter dated June 7, 2016, OWCP requested that she submit additional information to support her claim including medical evidence establishing that her total disability was due to the accepted condition for the period claimed.

Appellant subsequently submitted a May 5, 2016 report from Dr. Gary G. Poehling, a Board-certified orthopedist, who saw her for a six-month follow up after a bilateral knee replacement on November 18, 2015. Dr. Poehling noted findings for the bilateral knees of full range of motion for extension, flexion to 110 degrees, and tenderness of the medial joint line. He diagnosed chronic pain syndrome, primary osteoarthritis of both knees, and morbid obesity. Dr. Poehling prescribed pain medication and took appellant off work for one month to focus on recovery with physical therapy.

On June 24, 2016 appellant filed a claim for compensation (Form CA-7) for total disability from May 30 to June 9, 2016. On a time analysis form (Form CA-7a), appellant reported using LWOP for 10 hours a day from May 30 to June 6, 2016 and 7 hours a day from June 7 to June 9, 2016, due to doctor's excuse.

Appellant submitted June 23 and July 7, 2016 reports from Dr. Young who noted that appellant had bilateral knee replacements in November 2015 and continued to have significant issues with pain and weight bearing. Dr. Young noted that appellant continued to work her desk job as a transfer nurse four to five hours a day and often used a cane to get around. He noted findings of moderate discomfort when weight bearing, bilateral waddling antalgic gait, bilateral limp, both knees were painful on movement, with diffuse swelling. Dr. Young described intermittent red mottled appearance and burning pain in the knees which suggested complex regional pain syndrome (CRPS) and he recommended evaluation by a pain specialist. Appellant continued regular duty at her desk job as tolerated and noted that she was working four-hour shifts.

On July 29, 2016 appellant filed a claim for compensation (Form CA-7) for total disability from June 27 to July 8, 2016. On a time analysis form (Form CA-7a), appellant reported using LWOP for 6 hours a day from June 13 to 16, 2016, 5 hours of LWOP from June 20 to 23, 2016, 4 hours of LWOP on June 27 to 30, 2016, 3.5 hours of LWOP from July 5 and 6, 2016, and 4 hours of LWOP for July 7, 2016, due to doctor's excuse. On August 4, 2016 appellant filed a claim for

[4] *Supra* note 2.

compensation for LWOP for total disability (Form CA-7) from July 11 to 22, 2016. In a time analysis form (Form CA-7a), appellant requested LWOP for three hours a day from July 11 to 22, 2016 based on a doctor's excuse.

In an August 9, 2016 letter, OWCP noted appellant's claim for wage-loss compensation for the period beginning May 2, 2016 for a material change/worsening of her accepted work-related injury. It noted that after her original injury she returned to light-duty work on November 16, 2005 and continued working until May 2, 2016 when she stopped work completely. OWCP indicated that appellant's claim would be developed as a recurrence of disability and requested she submit additional factual and medical evidence.

Appellant subsequently submitted reports from Dr. Young, dated February 25 and June 25, 2015, who treated her for chronic left knee pain after an injury at work. Dr. Young diagnosed knee strain and continued her work status, regular duty at her desk job.

In a September 21, 2015 report, Dr. Poehling noted x-rays of the bilateral knees revealed primary osteoarthritis and severe narrowing of bilateral medial components. He recommended bilateral medial and possible patellofemoral unicompartmental knee arthroplasty. Dr. Poehling provided prior reports including his November 18, 2015 operative report in which he performed a bilateral unicompartmental knee arthroplasty.[5] He diagnosed bilateral medial compartment knee osteoarthritis. In a May 5, 2016 note, Dr. Poehling advised that appellant could return to work on June 6, 2016. In a May 5, 2016 outpatient referral request, he noted diagnoses and referred appellant for physical therapy. On June 6, 2016 Dr. Poehling returned appellant to work on June 7, 2016 for three hours a day and recommended she increase her workday by one hour a day each week. In an outpatient referral request dated June 6, 2016, he diagnosed chronic pain syndrome and referred appellant to the pain clinic.

In reports dated July 21 and August 22, 2016, Dr. Young noted that appellant had bilateral knee pain with neurologic-type pain laterally in both knees across the knee joints. He noted that appellant continued to work at a desk job for five hours a day, five days a week and reported being given more work than normal. Dr. Young noted findings on examination of moderate discomfort when she was weight bearing, bilateral waddling antalgic gait, bilateral limp, painful range of motion for both knees, and a burning sensation with light touch over the skin of the knees laterally. He advised that appellant had partial bilateral knee replacements in November 2015 and has done poorly since that time with significant pain with movement, pain in the joints, and possible CRPS. Dr. Young continued regular duty at her desk job as tolerated, 5 hours a shift and no more than 20 hours per week. Appellant also provided records from a physician assistant.

By decision dated September 12, 2016, OWCP denied appellant's claim for a recurrence of disability beginning May 2, 2016. It found that the evidence of record did not establish that she was disabled from work due to a material change or worsening of her accepted work-related condition.

[5] This procedure was not authorized by OWCP as work related.

Appellant timely requested an oral hearing which was held before an OWCP hearing representative on May 12, 2017. She testified that she could not work, effective May 2, 2016. Appellant returned to part-time work, three hours a day on or around June 7, 2016. She reported currently working five hours a day for four days a week.

Appellant was treated by Dr. Rudy Malayil, a Board-certified anesthesiologist, on September 9, 2016, for an 11-year history of left knee pain. She reported that her pain began in 2005 after a work injury and she underwent bilateral partial knee replacements on November 18, 2015. Dr. Malayil diagnosed CRPS.

Appellant submitted reports from Dr. Young, dated September 22 to December 23, 2016, who noted that appellant was seen in the pain management clinic and was diagnosed with CRPS. She continued to work at a desk job with an hourly restriction, but she had a hard time getting around due to pain. Dr. Young advised that appellant had partial bilateral knee replacements in November 2015 and has done poorly since that time with significant pain with movement, joint pain and the development of CRPS. Appellant reported being recently diagnosed with lung cancer and undergoing chemotherapy. Dr. Young continued regular duty at her desk job as tolerated, 5 hours a shift, and no more than 20 hours per week. On February 24 and May 1, 2017 he noted appellant's chronic knee joint pain limited her ability to work to about 20 hours weekly in a sedentary job. Appellant was currently working 10 hours a week due to lung cancer treatment. Dr. Young advised that the CRPS symptoms were slowly resolving and continued sedentary duty.

On June 5, 2017 Dr. Young noted the June 12, 2005 injury and diagnosed left knee sprain, bilateral post-traumatic osteoarthritis of both knees, derangement of the medial meniscus and joint space of both knees, reactive arthropathy of both knees, abnormality of gait, and CRPS. He opined that appellant's left knee injury did not resolve and it led to overcompensation in the right knee. Dr. Young noted that the pain and decreased function worsened and she underwent bilateral partial knee replacements and developed CRPS causally related to the June 12, 2005 work injury. He advised that appellant's abnormal gait and pain prevented her from working full time, which was due to her June 12, 2005 work injury.

In a statement dated June 14, 2017, appellant indicated that she had constant pain in both knees and could not function normally for years. She noted undergoing bilateral partial knee replacements and developed CRPS after surgery. Appellant advised that Drs. Young and Poehling prescribed aquatic therapy which helped reduce her pain and increase functionality, but OWCP denied coverage for the missed time from work to attend therapy. She indicated that on May 5, 2016 Dr. Poehling ordered her off work for one month to concentrate on physical therapy then ordered working a few hours a day to increase to 10 hours a day. Appellant provided a timeline noting her recent medical history and work limitations.

By decision dated July 5, 2017, the hearing representative affirmed the September 12, 2016 decision.

LEGAL PRECEDENT

A recurrence of disability means an inability to work after an employee has returned to work, caused by a spontaneous change in a medical condition resulting from a previous injury or illness without an intervening cause or a new exposure to the work environment that caused the illness. It can also mean an inability to work that takes place when a light-duty assignment made specifically to accommodate an employee's physical limitations due to his or her work-related injury or illness is withdrawn or when the physical requirements of such an assignment are altered so that they exceed his or her established physical limitations.[6]

When an employee who is disabled from the job he or she held when injured on account of employment-related residuals returns to a limited-duty position or the medical evidence of record establishes that he or she can perform the limited-duty position, the employee has the burden of proof to establish, by the weight of the reliable, probative, and substantial evidence, a recurrence of total disability and an inability to perform such limited-duty work. As part of this burden, the employee must show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the limited-duty job requirements.[7] To establish a change in the nature and extent of the injury-related condition, there must be a probative medical opinion, based on a complete and accurate factual and medical history as well as supported by sound medical reasoning, that the disabling condition is causally related to employment factors.[8] In the absence of rationale, the medical evidence is of diminished probative value.[9] While the opinion of a physician supporting causal relationship need not be one of absolute medical certainty, it must not be speculative or equivocal. The opinion should be expressed in terms of a reasonable degree of medical certainty.[10]

ANALYSIS

OWCP accepted that appellant sustained left knee medial meniscus tear and medial collateral ligament sprain after she tripped and twisted her knee at work. Appellant underwent arthroscopic surgery on October 19, 2005. She returned to light-duty work following the surgery in 2005 and continued to work in that capacity until May 2, 2016 when she stopped work. Appellant remained totally disabled through June 6, 2016 and returned to a part-time, limited-duty position, effective June 7, 2016. On June 1, 2016 she filed a Form CA-7, which OWCP developed as a recurrence of disability claim. The Board finds that the evidence of record lacks a well-reasoned narrative from appellant's physicians relating her claimed recurrent disability to her accepted employment injury. Furthermore, appellant has not presented evidence that the

[6] *J.F.*, 58 ECAB 124 (2006). A recurrence of disability does not apply when a light-duty assignment is withdrawn for reasons of misconduct, nonperformance of job duties, or other downsizing. 20 C.F.R. § 10.5(x). *See also Richard A. Neidert*, 57 ECAB 474 (2006).

[7] *A.M.*, Docket No. 09-1895 (issued April 23, 2010); *Terry R. Hedman*, 38 ECAB 222 (1986).

[8] *Mary A. Ceglia*, 55 ECAB 626, 629 (2004).

[9] *Id.*; *Robert H. St. Onge*, 43 ECAB 1169 (1992).

[10] *Ricky S. Storms*, 52 ECAB 349 (2001).

employing establishment either withdrew her light-duty job or altered the assignment so as to require her to exceed her physical restrictions before she stopped work.

Appellant submitted reports dated May 5, 2016 from Dr. Poehling who treated her for bilateral knee pain, swelling, and instability following a November 18, 2015 bilateral knee replacement. Diagnoses included: chronic pain syndrome, primary osteoarthritis of both knees, and morbid obesity. Dr. Poehling indicated that appellant was out of work for one month to focus on recovery with physical therapy. In a May 5, 2016 note, he advised that appellant could return to work on June 6, 2016. Similarly, on June 6, 2016, Dr. Poehling advised that appellant could return to work on June 7, 2016 for three hours a day and could increase her workday by one hour a day each week. However, he did not specifically address whether she had a recurrence of disability on May 2, 2016 causally related to the accepted employment conditions or otherwise provide medical reasoning explaining why any current condition or disability was due to the accepted June 12, 2005 work injury.[11] The record reveals that appellant returned to modified duty in 2005 and worked without apparent difficulty. Appellant underwent bilateral knee surgery in November 2015 which was not accepted or established to be work related and subsequently developed CRPS. There is no evidence that appellant's recurrent disability was due to the June 12, 2005 work injury, rather it appears to be attributable to the November 2015 surgery.

In June 23 and July 7, 2016 reports, Dr. Young noted that appellant had bilateral knee replacements in November 2015 and continued to have significant issues with pain and weight bearing. He noted findings and advised that appellant worked in her desk job as a transfer nurse four to five hours a day and often used a cane to get around. In reports dated September 22, 2016 to May 1, 2017, Dr. Young advised that appellant had done poorly since undergoing partial bilateral knee replacements in November 2015 with significant pain with movement, pain in the joints, and the development of CRPS. He failed to provide a rationalized opinion explaining the reasons why her recurrent disability and need for part-time work was due to the accepted work injury of June 12, 2005.[12] Rather, Dr. Young appears to attribute appellant's disability to CRPS developed after bilateral partial knee replacements. However, appellant's claim was not accepted for CRPS and bilateral partial knee replacement surgery was not authorized by OWCP as work related.[13]

On June 5, 2017 Dr. Young noted appellant's status and diagnosed left knee sprain, bilateral post-traumatic osteoarthritis of the knees, derangement of the medial meniscus and joint space of both knees, reactive arthropathy of both knees, abnormality of gait, and CRPS. He opined that the June 12, 2005 work injury to the left knee did not resolve and led to overuse of the right knee causing pain and dysfunction and ultimately bilateral partial knee replacements. Dr. Young advised that appellant could not work a full-time job due to these problems which stemmed from the June 12, 2005 work injury. He did not provide a rationalized and specific explanation of how she had a recurrence of disability on May 2, 2016 causally related to the accepted conditions. Instead,

[11] *Franklin D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value); *see Jimmie H. Duckett*, 52 ECAB 332 (2001).

[12] *Franklin D. Haislah, id.*

[13] For conditions not accepted by OWCP as being employment related, it is the employee's burden to provide rationalized medical evidence sufficient to establish causal relation, not OWCP's burden to disprove such relationship. *Alice J. Tysinger*, 51 ECAB 638 (2000).

Dr. Young generally indicated that the accepted injury led to appellant's current condition. The Board will not require OWCP to pay compensation for disability in the absence of any medical evidence directly addressing the specific dates of disability for which compensation was claimed. To do so would essentially allow employees to self-certify their disability and entitlement to compensation.[14] The Board further notes that Dr. Young did not address how a soft tissue sprain/strain and surgically repaired meniscal tear led to the development of the additional diagnoses and need for surgery in October 2015. Therefore this report is insufficient to meet appellant's burden of proof.

Other medical reports of record are of limited probative value as they either significantly predate the claimed recurrence of disability or do not specifically address whether appellant sustained a recurrence of disability on May 2, 2016 causally related to the accepted conditions.[15]

Appellant also submitted reports from a physician assistant. The Board has held that treatment notes signed by a physician assistant,[16] nurse, or physical therapist are not considered medical evidence as these providers are not considered physicians under FECA[17] and are not competent to render a medical opinion under FECA. Thus, this evidence is insufficient to meet appellant's burden of proof.

On appeal appellant asserts that her work-related condition was chronic and continued up until her work stoppage on May 2, 2016. However, as found above, the medical evidence submitted does not contain a rationalized medical opinion explaining why her claimed recurrent condition or disability on May 2, 2016 was due to the June 12, 2005 work injury.

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.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish a recurrence of disability on May 2, 2016 causally related to a June 12, 2005 employment injury.

[14] *William A. Archer*, 55 ECAB 674 (2004).

[15] *A.D.*, 58 ECAB 149 (2006) (medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

[16] *See S.E.*, Docket No. 08-2214 (issued May 6, 2009) (reports of a physician assistant have no probative value as medical evidence).

[17] *See David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006) (lay individuals such as physician assistants, nurses and physical therapists are not competent to render a medical opinion under FECA); 5 U.S.C. § 8101(2) (this subsection defines a "physician" as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law).

ORDER

IT IS HEREBY ORDERED THAT the July 5, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 23, 2018
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