

ISSUE

The issue is whether appellant has met her burden of proof to modify the July 24, 2013 wage-earning capacity determination.

On appeal counsel contends that a medical report dated March 25, 2016 was not properly considered by OWCP.

FACTUAL HISTORY

This case has previously been before the Board.⁴ The facts and circumstances as set forth in the prior Board decisions are incorporated herein by reference. The relevant facts are as follows.

On July 29, 1998 appellant, then a 35-year-old mail handler, filed an occupational disease claim (Form CA-2) alleging that she developed left foot plantar fasciitis due to walking and standing as part of her job duties. OWCP assigned the claim, File No. xxxxxx649 and accepted it for left plantar fasciitis. On October 27, 1998 it authorized wage-loss compensation benefits.⁵ Appellant returned to full-duty employment on July 14, 2000.

On September 15, 2004 appellant filed a traumatic injury claim (Form CA-1) alleging an acute lumbar sprain and right hand contusion and sprain when she fell backward at work. OWCP assigned the claim File No. xxxxxx781 and accepted it for lumbar and neck sprain as well as a right hand contusion.⁶

Appellant subsequently filed a traumatic injury claim (Form CA-1) alleging that on May 22, 2008 she sustained a low back strain/sprain when she felt resistance while lifting a door overhead and then a pinch in her back when she placed a lock on the door. OWCP assigned the claim File No. xxxxxx670 and accepted it for lumbosacral sprain on July 22, 2008.⁷

Appellant returned to light duty on February 8, 2009 as a modified mail handler. She filed claims for recurrence of disability (Form CA-2a) on September 10, 2009 and August 13, 2010 when the employing establishment was unable to provide work within her restrictions. Appellant stopped work completely on August 15, 2010. OWCP authorized wage-loss compensation benefits and later placed on the periodic rolls.

Dr. Michael E. Hebrard, a Board-certified physiatrist, examined appellant on January 5, 2011 and diagnosed lumbar spondylosis with chronic lumbar discogenic pain and lumbar spondylolisthesis related to her employment. On February 8, 2011 he diagnosed chronic lumbar strain, intermittent sciatica, and lumbosacral sprain.

⁴ Docket No. 12-0609 (issued July 18, 2012); Docket No. 15-0495 (issued May 13, 2015).

⁵ File No. xxxxxx649.

⁶ File No. xxxxxx781.

⁷ File No. xxxxxx670.

On December 27, 2010 OWCP referred appellant for a second opinion examination with Dr. John H. Welborn, a Board-certified orthopedic surgeon. On January 19, 2011 Dr. Welborn examined appellant and described her history of injury. He diagnosed lumbar sprain/strain and lumbar degenerative disc disease and opined that she had no residuals of the 2004 and 2008 work injuries. Dr. Welborn noted that appellant recovered from the lumbar sprain, but now had lumbar degenerative disc disease which was preexisting and nonindustrial. He opined that appellant's work restrictions resulted from her preexisting lumbar degenerative disc disease, not an employment injury.

On February 18, 2011 OWCP determined that there was a conflict of medical opinion between Drs. Hebrard and Welborn and referred appellant for an impartial medical examination with Dr. Justus Pickett, a Board-certified orthopedic surgeon. Dr. Pickett examined appellant on February 28, 2011 and found that she had no residuals or disability from her 2004 and 2008 falls and, therefore, did not qualify as an injured worker. He completed a work capacity evaluation indicating that appellant was not at maximum medical improvement (MMI) and that she had restrictions precluding her from performing her date-of-injury position.

On May 17, 2011 OWCP proposed to terminate appellant's wage-loss compensation and medical benefits based on Dr. Pickett's report. On July 1, 2011 it finalized the termination of her wage-loss compensation and medical benefits, effective July 3, 2011. Appellant requested reconsideration on September 8, 2011.

On August 30, 2011 appellant's podiatrist, Dr. Richard C. Lavigna, reported that appellant needed a plantar fascial release and heel spur removal. On November 14, 2011 Dr. Lavigna requested that OWCP expand appellant's claim under File No. xxxxxx649 to accept bilateral work-related plantar fasciitis.⁸

Appellant returned to full-time work on October 23, 2011.

By decision dated December 7, 2011, OWCP denied modification of its July 1, 2011 termination decision. Appellant requested reconsideration on September 8, 2011 and submitted additional medical evidence. On January 19, 2012 she appealed the December 7, 2011 decision to the Board.

By decision dated July 18, 2012,⁹ the Board reversed the December 7, 2011 OWCP decision. It found that OWCP had not met its burden of proof to terminate appellant's wage-loss

⁸ On December 22, 2011 appellant filed claims for wage-loss compensation (Form CA-7) for the periods of November 1 through 12, and 22, 2011 and January 30 to March 30, 2012. OWCP authorized benefits from October 10, 2011 through April 19, 2012. It authorized plantar fascial release and removal of the plantar calcaneal spur on January 10, 2012. On January 31, 2012 Dr. Lavigna performed this surgery on appellant's left foot. On May 2, 2012 OWCP accepted the additional conditions of right plantar fasciitis and left calcaneal spur and paid wage-loss compensation benefits.

⁹ Docket No. 12-0609 (issued July 18, 2012).

compensation and medical benefits as Dr. Pickett did not sufficiently address whether appellant's ongoing back condition was causally related to her work injuries.¹⁰

In a letter dated July 27, 2012, OWCP referred appellant for vocational rehabilitation services due to her accepted bilateral plantar fasciitis.

Dr. Lavigna, on August 9, 2012, indicated that appellant had an ongoing back injury with pain from her foot to her back. He indicated that she had scheduled an abdominal surgery that would disable her for up to 12 weeks. On October 29, 2012 Dr. Lavigna opined that appellant's heel surgery and slow healing aggravated her low back injury. He noted that heel surgery could take 18 months to heal.

Dr. Hebrard examined appellant on October 4 and November 2, 2012. He found that she had functional deficits in sitting, standing, and walking as a combination of her lumbosacral spine and plantar fasciitis conditions, in addition to gait balance and coordination issues due to foot pain which had caused biomechanical instability in the lumbosacral spine causing irritation of the lumbosacral nerve roots and aggravation of her back pain. Dr. Hebrard opined that appellant could stand and walk for no more than 25 minutes. He deemed her work status as sedentary with 20 minutes of standing and 45 minutes of sitting. On November 16, 2012 Dr. Hebrard diagnosed bilateral plantar fasciitis, calcaneal spur, compensable left ankle tibial tendon dysfunction, bilateral Achilles tendinitis, and aggravation of a preexisting lumbar spine condition secondary to calf tightness and gait instability. He reiterated that appellant's foot condition caused gait instability which resulted in tightness along the heel cords and tightness in the gastro soleus. Appellant's lumbar instability led to a lumbar strain and aggravation of sciatica. Dr. Hebrard found that appellant could return to work in a sedentary position.

On December 17, 2012 the vocational rehabilitation counselor identified two positions as appropriate for appellant, information clerk and cashier. She determined that appellant's training and work experience qualified her for a cashier position with vocational preparation of 30 days to 3 months, and the position of cashier was being performed in sufficient numbers so as to make it reasonably available within her commuting area. The vocational rehabilitation counselor further determined that the physical demands of the cashier position were sedentary with lifting up to 10 pounds and no climbing, balancing, stooping, kneeling, crouching, or crawling and noted that sedentary work involved sitting most of the time, but may involve walking or standing for brief periods of time. The weekly wage for a full-time cashier position was \$460.00

On December 19, 2012 OWCP referred appellant to Dr. Juon-Kin K. Fong, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a January 16, 2013 report, Dr. Fong noted that appellant had three injuries, bilateral plantar fasciitis, back contusions, and lumbar sprain. He reviewed her treatment records and performed a physical examination. Dr. Fong diagnosed bilateral plantar fasciitis and chronic lumbalgia with permanent aggravation of lumbar degenerative disc disease. He found that appellant did not require further treatment and recommended conservative care.

¹⁰ On August 30, 2012 OWCP authorized compensation benefits from July 3 through October 11, 2011. On September 5, 2012 it advised appellant that her claim was reopened for medical treatment due to her May 22, 2008 work injury.

After a February 15, 2013 functional capacity evaluation (FCE), Dr. Fong reviewed the findings in a report of February 26, 2013. He completed a work restriction evaluation form, noting that appellant was totally disabled from her date-of-injury job as she could no longer stand or walk as required, but that she could work eight hours a day. Dr. Fong restricted appellant to standing and walking for two to three hours. Appellant could bend and stoop for two hours; push up to 30 pounds for four hours; pull up to 30 pounds for four hours; lift up to 15 pounds for two hours; and do one hour each of squatting, kneeling, and climbing. He did not restrict sitting.

Dr. Hebrard completed examination notes on January 8, February 25, April 1 and 5, and May 22, 2013. He determined that appellant could stand for 20 to 25 minutes and walk longer than 25 minutes and provided that he sit, stand, and walk no more than 30 minutes. Dr. Hebrard opined that appellant needed time to stretch and reposition as her lower back interfered with her ability to sit for extended periods. He suggested 10-minute breaks every hour. Dr. Hebrard indicated that appellant should work no more than six hours a day exerting up to 20 pounds occasionally and 10 pounds frequently.

In a May 29, 2013 letter, OWCP proposed to reduce appellant's wage-loss compensation as she had the capacity to earn wages as a cashier at the rate of \$460.00 per week. It noted the restrictions set forth by Dr. Fong. OWCP afforded appellant 30 days to respond.

Appellant responded to the proposed reduction of compensation on June 28, 2013, noting her disagreement. She asserted that she was not physically able to stand for more than two or three hours a day and that she had not met with the vocational rehabilitation counselor.

On June 20, 2013 Dr. Hebrard reviewed Dr. Fong's report and FCE. He noted, "We will honor this assessment for the patient...." On July 3, 2013 Dr. Hebrard reported that appellant's back pain had decreased, but was exacerbated by sitting and standing. He noted that she could sit for 25 minutes, stand for 25 minutes and walk for 25 minutes. Dr. Hebrard noted that appellant could perform light-duty lifting up to 20 pounds occasionally and 10 pounds frequently. He found that she should work no more than 6 hours a day with 10-minute breaks every hour.

In a July 24, 2013 decision, OWCP finalized the reduction of compensation, finding that appellant had the capacity to earn wages as a cashier.

On October 16, 2013 appellant accepted a light-duty position from the employing establishment working eight hours a day as part of the sales retention team.¹¹ She was required to sit intermittently for eight hours a day with occasional standing. Appellant returned to work on October 23, 2013.

¹¹ In a letter dated October 1, 2014, OWCP noted that on October 2, 2013 the employing establishment offered appellant a job offer as a sales retention team agent which she accepted on October 23, 2013. However, it determined that it had prematurely terminated her compensation benefits and authorized additional benefits.

In a letter dated November 4, 2013, OWCP notified appellant that it was reducing her monetary compensation effective October 23, 2013 based upon her actual earnings as a sales retention team agent with weekly wages of \$1,019.12.

Following the reduction of her earnings appellant continued to submit reports from Dr. Hebrard in which he supported total disability and causal relationship between the diagnosed conditions and her work injuries.

On November 7, 2013 appellant filed a claim for compensation (Form CA-7) for the period November 4 to 6, 2013. In a letter dated November 18, 2013, OWCP requested that appellant provide additional medical evidence in support of her claim for a period of disability from November 4 to 6, 2013.

Dr. Hebrard provided notes dated November 5, 12 and 13, 2013 in which he indicated that appellant remained totally disabled and noted that she had a consequential emotional condition due to chronic pain from her work injuries.

On November 19, 2013 Dr. Hebrard noted that appellant reported ongoing low back pain radiating down her left buttocks and calf pain. He noted that she could perform modified duty work, but found her totally disabled from November 19 to 27, 2013. In a December 6, 2013 report, Dr. Hebrard noted that, beginning November 5, 2013, appellant had displayed emotional symptoms of crying and feelings of hopelessness, due to her back pain. He opined that her disability was causally related to her work injury. On December 10, 2013 Dr. Hebrard noted findings and determined that appellant was clinically depressed and totally disabled from work until she was stabilized on medication.

In a December 24, 2013 decision, OWCP denied appellant's claim for compensation for total disability from November 4, 2013 to November 6, 2013.

Dr. David Cohn, a Board-certified psychiatrist, examined appellant on December 3, 2013. He diagnosed major depressive disorder and noted that appellant had work injuries in 1998 for plantar fasciitis and 2008 for disc bulges. Dr. Cohn noted that appellant was disabled from work. On January 2, 2014 he repeated his diagnosis and, on January 14, 2014, he advised, "This depression was not present prior to her workers' compensation neuro-ortho injury, and is definitely related to it in a direct manner."

Appellant completed a series of claims for compensation (Form CA-7) requesting wage-loss compensation for leave without pay from December 10, 2013 through February 4, 2014. In a January 21, 2014 letter, OWCP noted appellant's several claims for compensation. It noted that a formal wage-earning capacity determination was in place based on the constructed position of cashier and that appellant had returned to work on October 23, 2013 in the full-time temporary position as a sales retention team agent. OWCP informed appellant that the evidence submitted was insufficient to meet her burden of proof to modify the existing wage-earning capacity determination. It afforded appellant 30 days to respond.

On January 28, 2014 Dr. Cohn diagnosed major depressive disorder, recurrent episode. He noted that appellant developed emotional symptoms after her work-related physical injuries had stopped her from working. Dr. Cohn opined that there was causal relationship between her

physical injuries and her emotional condition, noting that appellant was not suffering from major depression prior to her physical injuries.

In notes dated February 4 and 17, 2014, Dr. Hebrard, noted appellant's back pain and advised that she was diaphoretic and visibly trembling. More specifically, he found several small circumferential tears in the fibers of the disc which ultimately is aggravated with prolonged sitting, bending forward and twisting and walking activities. Dr. Hebrard explained that the pressure placed on the disc while sitting was causing increased axial loading, causing the disc to bulge out posteriorly, which puts pressure on the nerve and then causes radicular symptoms. He noted that sitting caused pressure on the disc and subsequent inflammation and pain. Dr. Hebrard opined that, due to her back condition, appellant developed major depressive mood disorder. He also diagnosed chronic pain syndrome and found her temporarily totally disabled, but could sit, stand, and walk for 20 minutes each. Dr. Hebrard noted that appellant fell approximately a week earlier, injuring her back and knees, and attributed this fall to appellant's medication for anxiety due to her chronic pain syndrome.

Dr. Cohn examined appellant on February 11 and 18, 2014. He diagnosed adjustment disorder with mixed anxiety and depressed mood. Appellant reported problems with balance that she attributed to medication. On March 4, 2014 Dr. Cohn noted that appellant had stopped work in November 2013. Diagnoses included pain disorder, unspecified major depression, and unspecified psychogenic pain.

On March 4, 2014 OWCP referred appellant for a second opinion examination with Dr. Mohinder S. Nijjar, a Board-certified orthopedic surgeon, and included a statement of accepted facts (SOAF) noting her back and foot conditions accepted for bilateral plantar fasciitis and left calcaneal spur.

On March 18, 2014 Dr. Hebrard noted that appellant was totally disabled from work through April 29, 2014. In a separate note of the same date, he noted that she appeared to be in moderate distress as she was sweating, and trembling. On March 31, 2014 Dr. Hebrard noted symptoms including muscle spasm in the back which he attributed to an aggravation of appellant's left foot condition. He explained that appellant's altered gait mechanics put more stress on the intervertebral discs in her lumbar spine. Dr. Hebrard noted, "Her tottering back and forth has led to increased stress along her pelvic musculature and subsequent muscle spasms in her lumbar paraspinal muscles and aggravation of her underlying lumbar spine disc disease.

On April 1, 2014 Dr. Cohn examined appellant. He reiterated his diagnoses and noted that she had significant depression related to her medical complications of foot surgery and back injury.

In an April 18, 2014 magnetic resonance imaging (MRI) scan appellant was noted to have small annular disc bulges and mild facet hypertrophy at L4-5 and L5-S1. An April 22, 2014 MRI scan showed L4-5 facet arthropathy with gapping and cartilage wear, minor discogenic change with annular bulging and subtle fissuring L4-5 and L5-S1 and neural foraminal narrowing.

Dr. Nijjar, in an April 30, 2014 report, reviewed the SOAF, listed appellant's accepted conditions, and reviewed the medical record. Examination revealed slight straightening of the curvature of the cervical spine with tenderness from C4 through C7. Dr. Nijjar also found paraspinal muscle spasm, more on the right, as well as loss of range of motion of the cervical and lumbar spine. He found straightening of the lumbar curvature with tenderness from L5-S1 to L3 and slight paraspinal muscle spasm more on the left. Appellant walked with a minimal limp. Leg reflexes were positive and equal. Appellant had decreased sensation over the outer aspect of the left thigh and no loss of motor strength. Dr. Nijjar diagnosed strain/sprain of the cervical, thoracic, and lumbar spine, degenerative disc disease with disc protrusion in the cervical and thoracic spine, as well as contusion of the right hand and bilateral plantar fasciitis, status post left foot surgery. He opined that appellant continued to have residuals of her work injuries in her neck, thoracic and lumbar spines.

Dr. Hebrard continued to find appellant totally disabled from work. On May 6, 2014 he noted, "Sitting and bending forward causes the disc fibers to bulge out posteriorly, putting pressure on the nerve endings. These nerves are not visible on the MRI scan, which is performed when the patient is unweighed. During the sitting process, the pelvis rotates backwards and the lumbar spine flattens. This leads to ongoing paresthesias and pain that she continues to have along with weakness in the lower extremities." Dr. Hebrard noted that appellant's depression was due to chronic pain from her work injuries. On May 9, 2014 he found that she had a combination of a sciatic neuropathy superimposed with a tarsal tunnel syndrome and nerve root entrapment of the feet leading to numbness and paresthesias. Dr. Hebrard opined that appellant had a biomechanical chain breakdown leading to aggravation of her preexisting cervical spine condition. He also opined that she had a consequential emotional condition.

In a June 9, 2014 decision, OWCP denied modification of its December 24, 2013 decision that denied compensation from November 4 through 6, 2013. It noted that appellant filed additional compensation claims for the period November 12 to December 11, 2013. OWCP found that the medical evidence of record did not address the specific periods of disability claimed.

In a July 21, 2014 report, Dr. Hebrard examined appellant's back and found chronic progressive impairment in her cervical and lumbar spine with persistent paresthesias and weakness in the upper and lower extremities. He opined that she had a recurrence of total disability from November 4 through 6, November 25 through 27, and December 9 through 11, 2013 due to a chronic deterioration of her condition and he recommended medical disability retirement. On July 24, 2014 Dr. Hebrard noted that appellant developed a consequential injury involving gastrocnemius muscle strain and Achilles tendinitis in the right leg as a result of her altered gait mechanics due to her left foot surgery. In reports dated August 20 and September 22, 2014, he continued to note examination finding and diagnoses, as well as supporting a causal relationship between her 2008 employment injury and her current conditions and disability.

In an October 24, 2014 report, Dr. Hebrard reviewed Dr. Nijjar's report and agreed with his conclusion that appellant had residuals of her work injuries. He also noted his prior opinion that appellant developed an emotional condition as a result of her chronic pain secondary to her spine and foot conditions including chronic pain syndrome and clinical depression.

Counsel requested reconsideration on November 12, 2014 and referred to Dr. Hebrard's October 24, 2014 report. Also submitted were November 11 and 14, 2014 notes from Dr. Hebrard reiterating that appellant's ongoing condition was due to her work-related injury.

By decision dated December 9, 2014, OWCP denied modification of its prior decision, finding that appellant had not established total disability beginning November 4, 2013. Appellant subsequently submitted reports from Dr. Hebrard dated January 6 and 27, 2015, which supported total disability and causal relationship between her current conditions and her work injuries.

On January 6, 2015 appellant appealed the December 9, 2014 decision to the Board.

On February 4, 2015 appellant requested that OWCP accept her claim to include a psychiatric condition. OWCP subsequently requested that she provide medical evidence in support of her claim for a consequential emotional condition. It afforded appellant 30 days to respond.

By decision dated February 11, 2015, OWCP denied appellant's claim for total disability for the period December 10, 2013 through February 14, 2014. On February 18, 2015 counsel requested an oral hearing, which was held on September 30 and November 4, 2015.

Appellant continued to treat with Dr. Hebrard and submitted additional reports supporting her claim for total disability, including reports of May 5 and 18, 2015. Dr. Hebrard opined that appellant had compensable sciatica, as well as an emotional condition of chronic pain syndrome and mood adjustment disorder and indicated that appellant could not perform her prior work duties.

By order dated May 13, 2015, the Board set aside the December 9, 2014 decision. The case was remanded to OWCP to combine all three of appellant's claims (File Nos. xxxxxx670, xxxxxx781, and xxxxxx649) and issue a *de novo* decision.¹²

On June 15, 2015 Dr. Lavigna diagnosed chronic plantar fasciitis, posterior tibial tendinitis, and heel pain. He also reported that appellant had low back and neck injuries. Dr. Lavigna noted that appellant had a hyperpronated gait.

In a report dated June 22, 2015, Dr. Robert Rover, a Board-certified orthopedic surgeon, described appellant's employment injuries to her back and feet. He noted that appellant stopped work in November 2013 as a result of spine and bilateral foot conditions. Dr. Rover reviewed appellant's diagnostic studies and diagnosed L4-5 spondylolisthesis, stenosis, and instability as well as L4-5 and L5-S1 spondylosis.

By decision dated October 14, 2015, OWCP denied appellant's claim for compensation for total disability beginning November 4, 2013. It found that she had not established a material change in the nature and extent of her injury-related conditions in File Nos. xxxxxx649 or xxxxxx670. OWCP expressly advised that it was not addressing a claim for modification of her

¹² Docket No. 15-0495 (issued May 13, 2015).

wage-earning capacity determination, but was only denying appellant's claim for total disability compensation.¹³

By decision dated December 7, 2015, an OWCP hearing representative set aside OWCP's February 11, 2015 decision and directed OWCP to consider all three of appellant's claims in addressing modification of her wage-earning capacity determination.

On January 13, 2016 appellant requested, again, that OWCP expand her orthopedic claim to include psychiatrist complications. In a letter dated February 1, 2016, OWCP requested additional medical evidence in support of her claim for a consequential emotional condition.

Appellant continued to submit reports from Dr. Hebrard. In reports dated January 18 and March 1 and 17, 2016, Dr. Hebrard noted that appellant had a material change in her lumbar condition and had developed a consequential emotional condition. He reported that she has a material change in her condition which ultimately led to problems with sleep disturbances, decreased functional endurance, low energy levels, and problems with focusing and concentration. Dr. Hebrard found that appellant had reached MMI.

Dr. George D. Karalis, a psychiatrist, examined appellant on March 25, 2016 and found that appellant's chronic pain caused major depression, which rendered her totally disabled from work. He noted that appellant last worked on November 8, 2013. Dr. Karalis explained that she had severe anxiety and depression. He noted that appellant developed chronic pain syndrome which caused heightened anxiety and depression, which enhanced her pain perception. Dr. Karalis noted, "Thus, a vicious cycle is set in motion: pain caused enhanced anxiety/depression, which in turn enhances pain perception, which in turn enhances anxiety/depression." He opined that appellant's orthopedic condition was and would continue to aggravate her mental condition. Dr. Karalis advised that appellant's mental illness developed a life of its own and could persist and remain totally disabling even after her orthopedic problem was controlled or eliminated. He attributed appellant's major depression to her employment injuries and found that she was totally disabled from work.

Dr. Lavigna examined appellant on April 28 and May 12, 2016 and diagnosed chronic plantar fasciitis and heel spur syndrome.

Additional reports of Dr. Hebrard dated April 28, June 16 and 27, and August 25, 2016 were submitted. He noted the diagnosed conditions and opined, "The cascade of biomechanical functional deficits has been a persistent function condition which has ultimately led to this chronic disability condition and subsequent to that the patient has yet to recover from the effects of her occupational injury involving her lumbar spine from May 22, 2008." Dr. Hebrard found that appellant was totally disabled from work.

Appellant testified during the oral hearing held on July 5, 2016. She noted that she had not worked since November 2013. Appellant continued to receive treatment for her feet, spine, and a psychiatric condition. She stopped work because of the walking required by her job. Appellant asserted the her job location was far from the elevators, that it was not on the same

¹³ Counsel timely requested an oral hearing regarding the October 14, 2015 decision.

floor as the cafeteria, and that she was not allowed to eat lunch in the break room. She testified that she had to walk and sit which was hard for her to do. Appellant noted that her feet began to swell and her back began to hurt, which caused her to become depressed.

By decision dated September 22, 2016, a hearing representative affirmed the February 11 and October 14, 2015 OWCP decisions. He found that appellant had not established a recurrence of disability commencing November 4, 2013. The hearing representative also found that appellant had not met her burden of proof to modify the July 24, 2013 wage-earning capacity determination.

LEGAL PRECEDENT

A wage-earning capacity decision is a determination that a specific amount of earnings, either actual earnings or earnings from a selected position, represents a claimant's ability to earn wages.¹⁴ Compensation for loss of wage-earning capacity is based upon loss of the capacity to earn and not on actual wages lost.¹⁵ Compensation payments are based on the wage-earning capacity determination, which remains undisturbed until properly modified.¹⁶

Modification of a standing wage-earning capacity determination is not warranted unless there is a material change in the nature and extent of the injury-related condition, the employee has been retrained or otherwise vocationally rehabilitated, or the original determination was erroneous.¹⁷ OWCP's procedures provide that, if a formal loss of wage-earning capacity decision has been issued, the rating should be left in place unless the claimant requests resumption of compensation for total wage loss. In this instance, the claims examiner will need to evaluate the request according to the customary criteria for modifying a formal loss of wage-earning capacity.¹⁸ The burden of proof is on the party attempting to show a modification of the wage-earning capacity determination is warranted.¹⁹

A medical report is of limited probative value on a given medical question if it is unsupported by medical rationale.²⁰ Medical rationale includes a physician's detailed opinion on the issue of whether there 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

¹⁴ 5 U.S.C. § 8115(a); *K.R.*, Docket No. 09-415 (issued February 24, 2010); *Lee R. Sires*, 23 ECAB 12, 14 (1971) (the Board held that actual wages earned must be accepted as the measure of a wage-earning capacity in the absence of evidence showing they do not fairly and reasonably represent the employee's wage-earning capacity).

¹⁵ *K.R.*, *id.*; *Roy Matthew Lyon*, 27 ECAB 186, 190 (1975). *Ernest Donelson, Sr.*, 35 ECAB 503, 505 (1984).

¹⁶ *See Sharon C. Clement*, 55 ECAB 552, 557 (2004).

¹⁷ *Sue A. Sedgwick*, 45 ECAB 211, 215-16 (1993); *Elmer Strong*, 17 ECAB 226, 228 (1965).

¹⁸ 20 C.F.R. § 10.511; Federal (FECA) Procedure Manual, Part 2 -- Claims, *Modification of Loss of Wage-Earning Capacity Decisions*, Chapter 2.1501. (June 2013).

¹⁹ *N.B.*, Docket No. 15-1749 (issued January 15, 2016); *Selden H. Swartz*, 55 ECAB 272, 278 (2004).

²⁰ *T.F.*, 58 ECAB 128 (2006).

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.²¹

The Board has held that OWCP may accept a limited period of disability without modifying a standing wage-earning capacity determination.²² This occurs when there is a demonstrated temporary worsening of a medical condition of insufficient duration and severity to warrant modification of a wage-earning capacity determination.²³

ANALYSIS

The issue on appeal is whether appellant's request for resumption of total disability compensation has been established, warranting modification of the July 24, 2013 wage-earning capacity determination. The Board finds that this case is not in posture for a decision.

Appellant alleged total disability beginning in November 2013. She has not returned to work. Therefore, the Board finds that this is not a temporary worsening of a medical condition, such that an analysis for a limited period of disability would be appropriate.²⁴ Instead this case must be analyzed as a request for modification of the July 24, 2013 wage-earning capacity decision, as amended for her work as a sales retention team manager.²⁵

There is no evidence supporting that appellant has been vocationally rehabilitated such that OWCP should modify the wage-earning capacity determination. Furthermore, appellant has not argued that the original July 24, 2013 wage-earning capacity determination was erroneous. OWCP accepted that she had bilateral plantar fasciitis and lumbar sprains due to her work injuries. The medical evidence of record established that appellant could no longer perform her date-of-injury job due to her accepted conditions, and OWCP referred her for vocational rehabilitation. Based on this, OWCP determined that position of cashier was appropriate considering work restrictions from Dr. Fong, Dr. Lavigna, and Dr. Hebrard, appellant's vocational preparation, her qualifications, and the reasonable availability of the position within her commuting area. The Board, therefore, finds that OWCP properly determined appellant's wage-earning capacity on July 24, 2013 and that it was properly modified for her work as a sales retention team manager by letter dated November 4, 2013.

In support of her request for total disability, appellant has submitted extensive medical reports from Dr. Hebrard addressing the progressive change in her accepted low back condition on and after November 4, 2013. She returned to work at the employing establishment in sedentary position in October 2013 sitting for eight hours a day. Dr. Hebrard found that

²¹ A.D., 58 ECAB 149 (2006).

²² N.B., *supra* note 19. See *Katherine T. Kreger*, 55 ECAB 633, 636 (2004).

²³ *Id.*

²⁴ S.J., Docket No. 16-1195 (issued January 4, 2017).

²⁵ *Id.*

appellant was totally disabled beginning November 4, 2013 due to her back pain and emotional condition. He has offered two explanations for appellant's worsening back condition and her total disability. Dr. Hebrard indicated that appellant's preexisting spinal degenerative disc disease continued to worsen. He noted, specifically, that there were several small circumferential tears in the fibers of the disc which ultimately aggravated with prolonged sitting, bending forward, twisting and walking. Dr. Hebrard explained that the pressure that is placed on the disc while sitting was causing increased axial loading resulting in the disc bulge posteriorly putting pressure on the nerve which then causes radicular symptoms. He opined that appellant's lower extremity condition and her return to work for this condition resulted in a consequential low back injury through prolonged periods of sitting and bending at the waist. On May 6, 2014 Dr. Hebrard noted that, "Sitting and bending forward causes the disc fibers to bulge out posteriorly, putting pressure on the nerve endings. These nerves are not visible on the MRI scan, which is performed when the patient is unweighed. During the sitting process, the pelvis rotates backward and the lumbar spine flattens. This leads to ongoing paresthesias and pain that she continues to have along with weakness in the lower extremities."

Dr. Hebrard further explained that appellant's altered gait mechanics due to her accepted bilateral plantar fasciitis and resulting surgery put more stress on the intravertebral discs in her lumbar spine. He noted, "Her tottering back and forth has led to increased stress along her pelvic musculature and subsequent muscle spasms in her lumbar paraspinal muscles and aggravation of her underlying lumbar spine disc disease." Dr. Hebrard explained that increased stress on the discs from her gait caused posterior disc bulging and impingement on adjacent nerve roots. On January 6, 2015 he opined, "This contraction of the piriformis muscle to externally rotate the hip compresses the sciatic nerve leading to paresthesias and weakness throughout the lower extremities, more so on the left than the right." On May 5, 2015 Dr. Hebrard opined that the gait change led to chronic posture changes aggravating her underlying lumbar condition resulting in muscle spasms and stress along the spinal column. He opined that appellant had compensable sciatica. On March 17, 2016 Dr. Hebrard described appellant's gait propulsion noting that in the plantar phase of her gait her foot hyperpronated leading to stretching and tearing of the plantar aponeurosis. This also led to compensatory mechanical gait disturbances leading to external rotation of the hip area and sciatic nerve compression. Dr. Hebrard opined that appellant had "a permanent aggravation of a sciatic nerve condition. A permanent aggravation of her plantar fibromatosis of her feet and with the surgery on the left, which she has never recovered from and there has been a material change in terms of decreased standing and walking tolerance as well as sleep disturbances."

Proceedings under FECA are not adversarial in nature, nor is OWCP a disinterested arbiter. While the claimant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done.²⁶ Dr. Hebrard had a complete history of appellant's accepted conditions and provided medical reasoning explaining how her accepted back condition changed due to her work injuries and activities. While these reports are insufficient to meet her burden of proof, they do raise uncontroverted evidence of a material change in appellant's accepted conditions and her total

²⁶ *J.K.*, Docket No. 11-1385 (issued February 7, 2012); *N.H.*, Docket No. 08-1503 (issued April 14, 2009).

disability from work and are sufficient to require OWCP to undertake further development of appellant's claim.²⁷

Furthermore, counsel asserts on appeal that OWCP failed to properly consider the medical report dated March 25, 2016. Counsel's argument is considered as a request for an expansion of the claim for a consequential emotional condition, which he claims also resulted in appellant's total disability, warranting modification of the wage-earning capacity determination. In the referenced note, Dr. Karalis, a psychiatrist, opined that appellant was totally disabled from work as a result of severe anxiety and depression caused by the chronic pain from her physical work injuries. He attributed the diagnosed severe anxiety and depression to her employment injuries, noting that "a vicious cycle is set in motion: pain caused enhanced anxiety/depression, which in turn enhances pain perception, which in turn enhances anxiety/depression."

In addition to the report of Dr. Karalis, a consequential emotional condition has been indicated by Dr. Hebrard. Dr. Hebrard reasoned that the progression of her physical injuries caused "a material change in her condition which has ultimately led to problems with sleep disturbances, decreased functional endurance, energy levels has been low, problems with focusing and concentration." He noted these symptoms caused disturbance with her ability to sleep.

It is an accepted principle of workers' compensation law that, when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause which is attributable to the employee's own intentional conduct.²⁸ Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.²⁹ The opinion of the physician must be based on a complete factual and medical background of the employee, 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 employment-related factor or incident.³⁰

The Board finds that both Dr. Karalis and Dr. Hebrard were presented with a complete factual and medical background of appellant's claims before OWCP and provided medical rationale in support of their opinions that appellant developed a consequential mental injury of severe anxiety and depression which is of sufficient probative value to warrant further development.³¹

²⁷ *John J. Carlone*, 41 ECAB 354, 358-60 (1989).

²⁸ *J.D.*, Docket No. 17-0767 (issued November 28, 2017); *Albert F. Ranieri*, 55 ECAB 598, 602; A. Larson, *The Law of Workers' Compensation* § 10.01 (2000).

²⁹ *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *D.I.*, 59 ECAB 158 (2007).

³⁰ *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 465 (2005).

³¹ *Supra* note 28.

On remand, OWCP should further develop the medical evidence as appropriate to obtain rationalized medical opinion evidence regarding whether the July 24, 2013 wage-earning capacity determination should be modified based on the progression of appellant's physical conditions or on the development of an emotional condition causally related to her accepted employment injuries. Following such further development of the case as OWCP deems necessary, it should issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for a decision.

ORDER

IT IS HEREBY ORDERED THAT the September 22, 2016 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this opinion of the Board.

Issued: January 23, 2018
Washington, DC

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

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

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board