United States Department of Labor
Employees' Compensation Appeals Board

S.P., Appellant	)	
	)	**Docket No. 16-1384**
and	)	**Issued: February 1, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant[1]
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
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On June 21, 2016 appellant, through counsel, filed a timely appeal from a March 17, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (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 appellant has met her burden of proof to establish ongoing total disability commencing January 11, 2010 due to her accepted employment injuries.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

On appeal counsel contends that, as OWCP accepted the additional condition of a consequential left fibula fracture, which rendered appellant partially disabled, she is entitled to wage-loss compensation as there is no evidence of record showing that the employing establishment provided appellant with an appropriate light-duty job offer after January 11, 2010.

FACTUAL HISTORY

On November 21, 2002 appellant, then a 41-year-old clerk, filed a traumatic injury claim (Form CA-1) alleging that on November 20, 2002 she tripped over a rug in the performance of duty and sustained a left knee displaced fracture. OWCP assigned File No. xxxxxx840. Appellant underwent left knee surgery on November 25, 2002 for tension band wiring of the left patella. OWCP accepted her claim on February 3, 2003 for fractured left patella. Appellant underwent a second left knee surgery on April 23, 2003 to remove the left patella hardware. She returned to full-time light-duty work on May 19, 2003.

On October 7, 2009 appellant filed a recurrence claim (Form CA-2a) alleging that she experienced weakness, pain, soreness, and swelling in her left knee. She noted that her left knee gave way and that she had difficulty standing and walking beginning in March 2009. On January 11, 2010 appellant reported that her left knee gave way at work and she fell, injuring her left ankle.

Appellant filed a second traumatic injury claim alleging that on January 11, 2010 her left knee gave out and she fell to the floor, twisting her left ankle. OWCP assigned the claim File No. xxxxxx746.[3] On March 26, 2010 OWCP requested additional factual and medical evidence in support of this traumatic injury claim.

By decision dated March 2, 2010, OWCP denied appellant's claim for recurrence of disability in March 2009.

In a note dated March 9, 2010, Dr. Michael J. Ross, Board-certified in emergency medicine, opined that appellant should not work and indicated that she could not stand or walk for more than one to two hours a day. On April 5, 2010 he noted that appellant continued to experience buckling episodes from her left knee. Dr. Ross diagnosed healing distal fibular fracture and left knee osteoarthritis with recurrent giving way. He recommended a magnetic resonance imaging (MRI) scan.

By decision dated April 30, 2010, OWCP denied her traumatic injury claim for a January 11, 2010 left ankle injury.

On June 9, 2010 Dr. Ross noted that appellant had continued pain in both her left knee and ankle as well as continuous giving way of her left knee requiring crutches. He reviewed MRI scans and found a healing distal fibular fracture in the left ankle and chronic patellar tendinitis in the left knee. Dr. Ross opined that appellant's left knee arthritis was accelerated by her patellar fracture. He noted, "I do question that the osteoarthritis secondary to the patellar

[3] File Nos. xxxxxx840 and xxxxxx746 were later administratively combined with xxxxxx840 serving as the master file.

fracture is also causing her knee to continuously give way which led to her initial fall that resulted in her fibular fracture."

Appellant requested reconsideration on October 13, 2010 and argued that her left knee arthritis was due to her November 20, 2002 employment injury.

Dr. Dennis W. Ivill, a Board-certified physiatrist, examined appellant on August 3, 2010 and diagnosed left knee degenerative joint disease causally related to her November 20, 2002 work injury when she fractured her left knee. He noted that the employment incident caused acceleration of her left knee degenerative joint disease which was not present in her right knee on bone scan.

In a decision dated January 11, 2011, OWCP denied modification of the April 30, 2010 decision, finding that the medical evidence of record did not support appellant's claim for recurrence of disability.

Appellant requested reconsideration. By decision dated February 8, 2012, OWCP denied modification of its prior decisions finding that she had not established a recurrence of her accepted left knee fracture beginning March 2009.

Appellant filed a second recurrence claim (Form CA-2a) on August 28, 2012. She alleged that her left knee "gave out" on January 11, 2010 and she fell to the floor, twisting her left ankle. Appellant asserted that her November 20, 2002 employment injury weakened her left knee and caused severe pain, stiffness, weakness, and swelling. She noted that she walked with a limp and had difficulty walking and standing.

In a decision dated November 28, 2012, OWCP denied appellant's August 28, 2012 recurrence claim, finding that there was insufficient medical reasoning of record to support that appellant's accepted November 20, 2002 left knee fracture resulted in her current knee condition.

On December 4, 2002 appellant, through counsel, requested an oral hearing from OWCP's Branch of Hearings and Review regarding the November 28, 2012 OWCP decision. At the oral hearing held on March 25, 2013, appellant described her November 20, 2002 left knee injury and explained that she returned to full duty in May 2004. In 2009 she developed severe pain, swelling and weakness in the left knee. Appellant walked with a limp and her knee buckled on an average of three times a week. She began wearing a knee brace or bandage. On January 11, 2010 appellant's left knee gave way and she fell to the floor twisting her left ankle. She was diagnosed with tibial fracture and did not return to work. Appellant testified that since January 11, 2010 she used crutches or a wheelchair for mobility.

In a June 13, 2013 decision, OWCP's hearing representative affirmed the November 28, 2012 decision as modified finding that appellant was in fact alleging that she had sustained a consequential injury, rather than a recurrence of disability. He determined that she had not submitted medical evidence sufficient to establish that she sustained a left ankle fracture as a consequence of her accepted left knee injury.

In a June 17, 2013 decision, OWCP denied appellant's claim for a consequential injury as a result of her November 20, 2002 employment injury. Counsel requested an oral hearing with OWCP's Branch of Hearings and Review on July 17, 2013.

On June 28, 2013 counsel requested reconsideration of the April 30, 2010 decision denying appellant's traumatic injury claim.

In a report dated August 15, 2013, Dr. Ivill noted that he initially examined appellant on June 25, 2010 due to left ankle, left knee, and left lower extremity pain. He reported that she fractured her patella on November 20, 2002. Dr. Ivill diagnosed chronic regional pain syndrome of the left lower extremity. He noted that appellant's January 11, 2010 fall was secondary to the original November 20, 2002 work injury which caused the left leg weakness and instability. Dr. Ivill opined that her left knee had given way regularly since her initial injury due to arthritis from her traumatic injury. He noted that complications associated with fracture of the patella included stiffness, swelling, atrophy, and arthritis. Dr. Ivill opined that on January 11, 2010 appellant's left knee gave out causing her to fall and fracture her left fibula down at the left ankle. In a December 4, 2013 note, he reported that she fell on November 23, 2013. Appellant reported left buttock pain since the fall. She underwent a lumbar MRI scan on November 11, 2013 which demonstrated disc herniation at L5-S1. Appellant underwent surgery on January 15, 2014 due to her left distal tibia fracture.

In a decision dated March 11, 2014, OWCP denied appellant's June 28, 2013 request for reconsideration, finding that it was untimely filed and failed to demonstrate clear evidence of error.

By decision dated March 18, 2014, OWCP's hearing representative vacated the June 17, 2013 decision, finding that OWCP should refer appellant for a second opinion evaluation based on Dr. Ivill's August 15, 2013 report.

On March 21, 2014 OWCP referred appellant for a second opinion evaluation with Dr. Noubar A. Didizian, a Board-certified orthopedic surgeon. In a report dated April 17, 2014, Dr. Didizian noted appellant's history of injury on November 20, 2002 and her resulting fractured left patella. He further related that appellant reported that on January 11, 2010 her left knee collapsed and she fell fracturing her left distal fibula. Dr. Didizian examined appellant's left knee and found 10 to 90 degrees of motion. He reported crepitation at the patellofemoral joint with positive inhibition and compression test. Dr. Didizian also found weak extensor halluces longus on the left and decreased sensation in the left lower extremity from the knee down. He diagnosed degenerative disease of the left patellofemoral joint and malalignment. Dr. Didizian found that appellant's patellar fracture was a direct result of her work injury. He noted that appellant could perform limited duty.

In an April 28, 2014 e-mail, OWCP noted that Dr. Didizian did not provide an opinion on appellant's alleged consequential injury. On June 16, 2014 it asked that Dr. Didizian clarify whether her left ankle fracture occurred as a result of her accepted left knee injuries. In a report dated June 16, 2014, Dr. Didizian opined that appellant's left ankle fracture was a consequence of her November 20, 2002 work injury. OWCP accepted the claim for open fracture of the left fibula on June 20, 2014.

Dr. Bruce Lutz, a Board-certified orthopedic surgeon, examined appellant on July 19, 2014 noting that she fell on June 14, 2014 when her left knee gave way. Appellant underwent an electromyogram (EMG) and nerve conduction velocity (NCV) study on June 20, 2014 which suggested possible upper motor neuron lesion. On July 8 and 17, 2014 Dr. Ivill opined that

appellant's January 10, 2014 injury was causally related to her November 2002 work injury as her left lower extremity symptoms and pain caused her fall. On July 23, 2014 appellant underwent a thoracic spine MRI scan which demonstrated multilevel degenerative disc disease throughout the thoracic spine most significant at the T8-9 level with disc protrusions at T7-8, T8-9, and T11-12. Her lumbar MRI scan of July 23, 2014 demonstrated mild degenerative disc disease at T11-12 with a small right disc protrusion. Appellant also exhibited degenerative disc disease at L2-3, L3-4, L4-5, and L5-S1 with disc bulges.

Appellant filed claims for compensation (Form CA-7) requesting compensation for leave without pay from February 26 through December 3, 2010 and from April 2, 2011 through December 12, 2014. In a letter dated August 28, 2014, OWCP requested that appellant provide medical evidence supporting her total disability from work due to her accepted consequential injury.

In a report dated August 28, 2014, Dr. Ivill reviewed appellant's thoracic spine MRI scan and found marked right anterior displacement of the thoracic cord at T6-7. He diagnosed transdural cord herniation. On September 12, 2014 Dr. Ivill attributed appellant's osteoporosis, left tibial fracture, and falls on November 23, 2013 and January 10, 2014 to her November 20, 2002 employment injury. He examined appellant on October 1, 2014 and opined that her November 20, 2002 employment injury resulted in her January 11, 2010 fall, and left leg weakness and instability, as well as complex regional pain syndrome. Dr. Ivill also described appellant's November 23, 2013 and January 10, 2014 falls with left tibial fracture and "possible thoracic myelopathy." Appellant underwent a computerized tomography scan of her thoracic spinal cord on September 16, 2014 which confirmed transdural cord herniation at T6-7.

On February 10, 2014 the employing establishment indicated that neither accommodation nor reassignment were possible. It provided appellant with a notification of personnel action (Form SF-50) indicating that her last day in pay status was July 26, 2014 and that she was totally disabled from useful and efficient service in her position. Appellant received disability retirement on October 20, 2014.

On November 20, 2014 appellant elected to receive FECA benefits, effective January 11, 2010.

By decisions dated December 18 and 19, 2014, OWCP denied appellant's claims for compensation from February 26 through December 3, 2010 and April 2, 2011 through December 12, 2014. Counsel requested an oral hearing from OWCP's Branch of Hearings and Review on December 29, 2014.

Appellant underwent surgery on March 30, 2015 to repair a thoracic T6-7 transdural spinal cord herniation including a T5-8 posterior arthrodesis with autograft and a T6-7 complete laminectomy.

In a decision dated May 11, 2015, OWCP's hearing representative found that the case required further development by OWCP. She noted that appellant stopped work in January 2010 due to a consequential injury and that OWCP accepted this injury based on the opinion of Dr. Didizian. The hearing representative noted that Dr. Didizian opined that appellant could not perform her regular duties due to her work injuries. She further noted that the record did not

indicate that light duty was available to appellant. The hearing representative remanded the case for OWCP to combine appellant's files, update the statement of accepted facts, and request a supplemental report from Dr. Didizian regarding the extent of appellant's disability since January 11, 2010. She also noted that the employing establishment should confirm whether appellant was offered light duty for any period after January 11, 2010.

In a May 27, 2015 e-mail, OWCP requested that the employing establishment confirm if appellant was offered light duty for any period after January 11, 2010. The employing establishment responded on May 28, 2015 and indicated that the medical evidence submitted supported total disability from January 11, 2010. OWCP again requested information from the employing establishment regarding available light-duty work on July 8, 2015.

OWCP requested additional information from Dr. Didizian on July 8, 2015.

Dr. Ivill completed a report on July 8, 2015 and attributed appellant's January 11, 2010 fall to her November 20, 2002 employment injury. He noted that the 2010 fall caused left lower extremity weakness, instability and complex regional pain syndrome. Dr. Ivill also reported appellant's falls on November 23 and January 10, 2014 with an additional left tibial fracture. He noted that appellant underwent thoracic fusion on March 30, 2015 and recently fell again.

On September 2, 2015 OWCP referred appellant for an additional second opinion evaluation with Dr. Didizian. In a September 10, 2015 report, Dr. Didizian noted that appellant denied any prior mid-back pain from 2010. He noted that appellant had thoracic surgery on March 30, 2015 for myelomalacia to prevent her neurological condition from worsening. Appellant continued to describe left knee buckling, aching, and pain. Dr. Didizian examined appellant's lower extremities and found hyperreflexia of the knee reflex and decreased sensation in the left leg in all dermatomes. He noted that appellant had no extensor hallucis longus resistance, peroneal resistance, or tibialis anterior resistance on the left. Dr. Didizian reviewed the medical evidence and opined that appellant's left leg weakness was due to a thoracic disc injury discovered in June 2014 and not her left knee. He disagreed with Dr. Ivill's diagnosis of reflex sympathetic dystrophy. Dr. Didizian found that appellant's left lower extremity fractures had healed and that she could perform modified duty. OWCP requested that he provide an opinion on appellant's periods of partial and total disability beginning in January 2010. Dr. Didizian responded, "Partially disabled from left knee patella femoral arthritis. Totally disabled from thoracic spine surgery." He completed a work capacity evaluation.

OWCP issued a decision on October 16, 2015 denying appellant's claims for compensation for the periods February 26 through December 3, 2010 and April 2, 2011 through October 2, 2015.

Counsel requested an oral hearing on October 28, 2015. He appeared at the oral hearing on February 8, 2016 and argued that the employing establishment failed to provide appellant with light-duty work, and that Dr. Didizian failed to specifically address any periods of partial disability due to appellant's accepted employment injuries.

By decision dated March 17, 2016, OWCP's hearing representative found that appellant was entitled to compensation for total disability for the period January 11 to February 1, 2010, but that appellant had not filed a claim for this period. He further denied her claim for wage-loss

compensation benefits from February 2, 2010 forward as her total disability from that point forward was due to nonoccupational conditions. The hearing representative noted that appellant could have worked limited duty after February 2, 2010 due to her accepted knee fractures, but that she was totally disabled due to other conditions and the employing establishment was not required to offer restricted duty to a totally disabled employee.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim, including that any disability or specific condition for which compensation is claimed is causally related to the employment injury.[4] The term disability is defined as the incapacity because of an employment injury to earn the wages the employee was receiving at the time of the injury, *i.e.*, a physical impairment resulting in loss of wage-earning capacity.[5]

Whether a particular injury causes an employee to be disabled for employment and the duration of that disability are medical issues which must be proved by a preponderance of the reliable, probative, and substantial medical evidence.[6] Findings on examination are generally needed to support a physician's opinion that an employee is disabled for work. When a physician's statements regarding an employee's ability to work consist only of repetition of the employee's complaints that he or she hurts too much to work, without objective findings of disability being shown, the physician has not presented a medical opinion on the issue of disability or a basis for payment of compensation.[7] 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 is claimed. To do so would essentially allow employees to self-certify their disability and entitlement to compensation.[8]

Causal relationship is a medical issue and the medical evidence required to establish causal relationship is rationalized medical evidence.[9] Rationalized medical evidence is medical evidence which includes a physician's detailed medical opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. 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.[10] Neither the fact that a disease

[4] *G.T.*, 59 ECAB 447 (2008); *Kathryn Haggerty*, 45 ECAB 383 (1994); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[5] 20 C.F.R. § 10.5(f); *see, e.g., Cheryl L. Decavitch*, 50 ECAB 397 (1999) (where appellant had an injury but no loss of wage-earning capacity).

[6] *See Fereidoon Kharabi*, 52 ECAB 291 (2001).

[7] *Id.*

[8] *Id.*

[9] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[10] *Leslie C. Moore*, 52 ECAB 132 (2000).

or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[11]

ANALYSIS

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

On June 20, 2014 OWCP accepted appellant's claim for a consequential left ankle fracture on January 11, 2010 resulting from her November 20, 2002 employment injury. Appellant filed claims for compensation requesting wage-loss compensation from February 26 through December 3, 2010 and from April 2, 2011 through December 12, 2014. On May 11, 2015 OWCP's hearing representative remanded the case for OWCP to obtain a supplemental report from Dr. Didizian addressing appellant's periods of total and partial disability due to her consequential left ankle injury. OWCP requested that Dr. Didizian provide an opinion on appellant's periods of partial and total disability beginning in January 2010. Dr. Didizian responded, "Partially disabled from left knee patella femoral arthritis. Totally disabled from thoracic spine surgery." He also completed a work capacity evaluation. The Board finds that this report from Dr. Didizian failed to fully respond to OWCP's queries and did not address, much less resolve, the ongoing issue of appellant's period of partial and total disability due to her accepted employment injuries.

Proceedings before OWCP are not adversarial in nature and OWCP is not a disinterested arbiter. In a case where OWCP "proceeds to develop the evidence and to procure medical evidence, it must do so in a fair and impartial manner."[12] The Board finds that OWCP undertook further development of the medical evidence regarding the issue of periods of partial and total disability causally connected to her accepted employment condition of fracture of her left ankle, by referring appellant to Dr. Didizian for a supplemental report, but failed to obtain a response to the questions posed. As Dr. Didizian did not fully respond, and as the employing establishment failed to respond to the queries regarding light-duty work, the Board finds that the case must be remanded to OWCP for further development of these issues and a *de novo* decision.

CONCLUSION

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

[11] *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

[12] *Walter A. Fundinger, Jr.*, 37 ECAB 200, 204 (1985).

ORDER

IT IS HEREBY ORDERED THAT the March 17, 2016 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further development consistent with this decision of the Board.

Issued: February 1, 2017
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