United States Department of Labor
Employees' Compensation Appeals Board

C.S., Appellant	)	
	)	**Docket No. 11-1875**
and	)	**Issued: August 27, 2012**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Leavenworth, KS, Employer	)	

Appearances:
Cerita J. Slusher, pro se
Office of Solicitor, for the Director

Oral Argument May 8, 2012

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On June 15, 2011 appellant filed a timely appeal from the May 2, 2011 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.

ISSUE

The issue is whether appellant met her burden of proof to establish that her claim should be accepted for a consequential injury to both knees, lumbar spine and right elbow and whether her claim should be accepted for aseptic necrosis of the medial femoral condyle of both knees.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On January 7, 2002 appellant, then a 45-year-old supervisor, slipped on ice and injured her low back in the performance of duty.[2] OWCP accepted the claim for a lumbar strain.[3] It subsequently accepted bilateral chondromalacia, abrasion and friction of the right elbow, bilateral meniscus tears with surgical repairs, abrasion and friction burn of the right elbow, bilateral knee contusions, herniated disc at L4-5 nerve roots with a lumbar microdiscectomy performed on October 2, 2002. OWCP also accepted aseptic necrosis of the left humerus on November 20, 2009. Under claim No. xxxxxx010, appellant was struck on the left side while entering an elevator on June 9, 1998. OWCP accepted a left shoulder sprain, lumbar back sprain and neck sprain, resolved effective July 10, 1998, aggravation of degenerative osteoarthritis of the left shoulder, left shoulder impingement syndrome and left shoulder arthroscopy performed on December 28, 1999. Appellant stopped work on December 28, 1999 and returned to regular duty on August 3, 2000.[4] All of the claims were combined under the present claim.

Appellant received treatment from her physician, Dr. S.R. Reddy Katta, a Board-certified physiatrist, who opined that appellant had chronic low back pain from degenerative joint disease and degenerative lumbar disc disease with lumbar radiculitis. In a September 15, 2008 report, Dr. Katta opined that, while on vacation, appellant fell and injured her left knee again. He diagnosed chronic cervical thoracic and lumbosacral sprain from a fall on October 3, 2007 and sprain of the right ankle and chronic lower back pain from degenerative disc disease and joint disease of both knees with tendinitis over medial aspect of both knees and reflex sympathetic dystrophy (RSD) in both legs.

On September 1, 2009 OWCP referred appellant together with a statement of accepted facts (SOAF) and the medical record, to Dr. Garth Russell, a Board-certified orthopedic surgeon, for an impartial medical evaluation to resolve a conflict in opinion between Drs. Katta and an OWCP medical adviser. In the questions for the examining physician, OWCP requested that the impartial medical adviser review diagnostic tests of the cervical and thoracic spine and provide an opinion as to whether she suffered from consequential injuries involving her cervical and thoracic spine and right shoulders causally related to her employment injuries of June 9, 1998 and January 7, 2002.

In a September 9, 2009 report, Dr. Katta diagnosed chronic low back pain from degenerative disc disease and degenerative joint disease of the lumbar vertebrae with left lumbar radiculitis and left trochanteric bursitis. He advised that appellant's magnetic resonance imaging

[2] Appellant has several claims and several prior appeals before the Board. The most relevant appeal before the Board includes an October 5, 2010 decision. In that appeal, the Board found that appellant did not meet her burden of proof to establish that her neck, thoracic and right shoulder conditions are consequential to her accepted injuries. Docket No. 10-214 (issued October 5, 2010). The facts and history contained in the prior appeals are incorporated by reference. Relevant portions have been repeated.

[3] The record reflects that appellant filed additional claims for an injury on December 20, 2006 and October 3, 2007 in which she alleged that her legs gave out at work. OWCP accepted these claims.

[4] Appellant's nonwork-related conditions include: menopause, osteopenia, allergic rhinitis, depression, diabetes, arthritis, sleep apnea, mitral valve prolapse, hypertension, pituitary insufficiency with adult growth hormone deficiency, central obesity, hyperlipidemia, mild chronic obstructive pulmonary disease and mild coronary artery disease. OWCP also noted that in September 2008, appellant was on vacation and fell and reinjured her left knee.

(MRI) scan did not reveal any significant new problems but that it showed multilevel degenerative disc disease without any herniation or spinal stenosis.

In a September 24, 2009 report, Dr. Russell reviewed appellant's history and treatment. He examined appellant and presented findings. Dr. Russell determined that appellant's lumbar strain of January 2, 2002, resolved within 90 days. He also noted that appellant sustained a fall on September 6, 2002 and opined that it had no relationship to her injury to her back. Dr. Russell explained that a person with an ongoing low back injury would be unable to ride a bicycle or position their back to ride a bicycle. He opined that the back injury from the fall on the bicycle was the source of the lower back injury, which required surgery to both her back and knees. Dr. Russell also indicated that her fall on January 9, 2007 and the expansion of her claim to include her shoulder, neck, right elbow and thoracic was secondary to the fall with the injury to her back on September 6, 2002. Regarding the left shoulder, he opined that the June 9, 1998 incident was responsible for her left shoulder strain, lumbar sprain and impingement syndrome. Dr. Russell explained that it would have resolved within three to six months and would not have been the etiology of the recurrence of her neck and back pain on March 12, 2001. He noted that diagnostic reports of the cervical and lumbar spine revealed degenerative disc disease that was the product of genetics and aging and not to her specific job-related injuries. Dr. Russell also advised that the May 31, 2006 claim in which appellant twisted her body when attempting to sit in a chair did not produce an injury to the back hips, legs or knees. He opined that the injury to the left shoulder was work related. However, the injury to appellant's back, neck, upper back and knees occurred following the fall from the bicycle of September 6, 2002 was not job related. Dr. Russell explained that the presence of a lumbar strain more than six months old would not have had any relation to the injury to her back, knees or neck. He advised that, because of her chondromalacia and degenerative changes in her knees and spine, she would continue to have pain in her neck, upper and lower back, hips and knees. Dr. Russell noted that this would occur with activities of daily living and normal motion. He opined that the fall or injuries were secondary to normal activity and not due to her employment.

On October 29, 2009 OWCP issued a proposal to rescind the accepted conditions of the lumbar spine, bilateral knee conditions and right elbow conditions. By decision dated December 1, 2009, it affirmed the rescission.

On December 25, 2009 appellant requested a hearing. In a May 5, 2010 decision, a hearing representative remanded the claim for further development of the medical evidence. He found that Dr. Russell's report required clarification as information in the SOAF provided to Dr. Russell was erroneous. The hearing representative noted that OWCP accepted that appellant's September 6, 2002 fall was consequential to her January 7, 2002 injury. OWCP was directed to correct the SOAF and request a supplemental report from Dr. Russell.

In a March 12, 2010 report, Dr. Katta opined that appellant had lower back pain radiating to both leg, on the right side more than the left side. He noted that appellant had dealt with the lower back pain since the initial fall in 2002 and several falls since then. Dr. Katta opined that appellant continued with lower back pain and has been working on a regular basis. He explained that he did not see any other problem causing her back pain other than what resulted from her falls. Dr. Katta diagnosed: chronic lower back pain from degenerative disc disease, degenerative joint disease of lumbar vertebrae with some degree of lumbar spinal stenosis with left lumbar radiculitis and left trochanteric bursitis and posterior shoulder girdle muscle strain without any clinical evidence of cervical radiculopathy.

By letter dated May 27, 2010, OWCP advised that appellant's examination was scheduled with Dr. Russell on June 23, 2010. It provided Dr. Russell with an updated and corrected SOAF, that stated: on September 6, 2002 appellant sustained a fall after she rode her bike around the block, when she got off her bike she stated her legs were red, and then gave out, causing her to fall onto the ground, landing on her knees. This fall was accepted as a consequence of her January 2, 2002 work injury and accepted for bilateral chondromalacia of the patella.

In a June 4, 2010 supplemental report, Dr. Russell noted appellant's history of injury and treatment and the updated SOAF. He addressed whether appellant had objective medical evidence to substantiate that her current low back, bilateral knee and right elbow conditions were causally related to her accepted work-related injuries or the consequential injury of September 6, 2002. Dr. Russell referred to his prior report of September 24, 2009, and opined that appellant had preexisting degenerative disc disease of her lower back. He noted that the medical evidence revealed back pain since the initial injury occurring on June 9, 1988, when she was struck by an elevator door. Dr. Russell also noted that the MRI scan at that time revealed mild herniation of the L4-5 disc on the left. He explained that the symptoms in her back were controlled and subsided until the bicycle injury of September 6, 2002. Dr. Russell opined that a person "who has low back pain with a herniated disc is unable to ride on a bicycle inasmuch as the position of the back aggravates muscle spasm and any nerve root pressure which might be present." He further noted that when appellant "got off of the bike that her knees were red and her legs buckled causing her to fall to the ground landing on her knees." Dr. Russell explained that the "presence of degenerative disc disease with back pain and muscle spasm does not cause the legs to buckle or sudden nonfunctioning of the musculature of the lower extremities. A disc injury with herniation causes localized nerve root pressure, but not for the buckling of both lower extremities." Dr. Russell opined that appellant had "degenerative disease in her lower back. This was aggravated by the fall of September 6, 2002, after riding the bike. This did aggravate her degenerative disc disease with radiculopathy." Dr. Russell noted that appellant underwent a microdiscectomy about six weeks later. He also opined that "the fall of September 6, 2002, was not secondary to the previous back injury as it would not have caused the legs to buckle. The continued difficulty with buckling of her knees and the continued knee pain with arthroscopy was consistent with and secondary to the injury of September 6, 2002. This was confirmed by examination on the following day, which revealed ecchymosis and contusions, particularly over the left knee. In addition, there was a congenital abnormality of a shallow patellofemoral groove, which produces chondromalacia. The right elbow symptoms are consistent with and secondary to her bilateral carpal tunnels with repetitive work injuries." Dr. Russell opined that "the symptoms, surgery and treatment to her knees bilaterally were not associated with the multiple injuries which she described as job related and are secondary to the fall of September 5, 2002." He repeated his belief that the present symptoms in her low back and her knees bilaterally were secondary to the fall on September 6, 2002.

On August 19, 2010 OWCP issued a proposal to rescind medical benefits for all conditions and expansion of the claim.

In a September 30, 2010 decision, OWCP terminated appellant's compensation and medical benefits for lumbar, knee, and right elbow conditions and denied expansion of the claim to include aseptic necrosis of the medial femoral condyle of the bilateral knees.

On October 10, 2010 appellant requested a telephonic hearing, which was held on February 10, 2011. At the hearing, she questioned the integrity of the impartial medical examiner, noting that he seemed to be more interested in chatting with her husband about the history than her physical examination. Appellant also explained that the history was incorrect. She indicated that she did not ride her bicycle in September 2002, but rather, she was contemplating riding the bike and standing in front of her home when her legs gave out. Appellant also testified that she was already scheduled for back surgery when her legs buckled on September 5, 2002.

On May 2, 2011 OWCP's hearing representative affirmed the September 30, 2010 decision.

LEGAL PRECEDENT

The general rule respecting consequential injuries is 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.[5] The subsequent injury is compensable if it is the direct and natural result of a compensable primary injury.[6] With respect to consequential injuries, the Board has stated that, where an injury is sustained as a consequence of an impairment residual to an employment injury, the new or second injury, even though nonemployment related, is deemed, because of the chain of causation to arise out of and in the course of employment and is compensable.[7]

FECA provides that, if there is disagreement between the physician making the examination for OWCP and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[8]

ANALYSIS

The Board finds that this case is not in posture for decision on the issue of whether appellant has established that her claim should be expanded to include a consequential injury to her bilateral knees, lumbar spine and right elbow on September 6, 2002 and whether her claim should be expanded to include aseptic necrosis of the medial femoral condyle of the bilateral knees.

The Board finds that a conflict did not exist at the time of the referral to Dr. Russell. While OWCP noted that its September 1, 2009 referral to Dr. Russell was due to a conflict that had arisen between Dr. Katta and an OWCP medical adviser, the Board finds that the issue in this claim pertains to appellant's claim of a consequential injury to both knees, lumbar spine and right elbow on September 6, 2002 and whether her claim should be expanded to include aseptic

[5] *Albert F. Ranieri*, 55 ECAB 598 (2004).

[6] *Id.; Carlos A. Marrero*, 50 ECAB 117 (1998); A. Larson, *The Law of Workers' Compensation* § 10.01 (2005).

[7] *Kathy A. Kelley*, 55 ECAB 206 (2004).

[8] 5 U.S.C. § 8123(a); *Shirley L. Steib*, 46 ECAB 309, 317 (1994).

necrosis of the medial femoral condyle of both knees. At the time that appellant was previously referred to Dr. Russell, the referral was related to whether her neck, thoracic and right shoulder conditions were consequential to her accepted injuries.[9]

The Board finds that a conflict has now arisen between Dr. Katta and Dr. Russell on whether her claim should be expanded for consequential injury to both knees, lumbar spine and right elbow on September 6, 2002 or for aseptic necrosis of the medial femoral condyle of the both knees.

The Board notes that Dr. Russell was provided with an updated and corrected SOAF and clarified his opinion. In a June 4, 2010 supplemental report, Dr. Russell opined that a person "who has low back pain with a herniated disc is unable to ride on a bicycle inasmuch as the position of the back aggravates muscle spasm and any nerve root pressure which might be present." He opined that appellant had "degenerative disease in her lower back. This was aggravated by the fall of September 6, 2002, after riding the bike. This did aggravate her degenerative disc disease with radiculopathy." Dr. Russell noted that appellant underwent a microdiscectomy approximately six weeks later. He also opined that "the fall of September 6, 2002, was not secondary to the previous back injury as it would not have caused the legs to buckle. The continued difficulty with buckling of her knees and the continued knee pain with arthroscopy was consistent with and secondary to the injury of September 6, 2002. This was confirmed by examination on the following day, which revealed ecchymosis and contusions, particularly over the left knee. In addition, there was a congenital abnormality of a shallow patellofemoral groove, which produces chondromalacia. The right elbow symptoms are consistent with and secondary to her bilateral carpal tunnels with repetitive work injuries." Dr. Russell opined that "the symptoms, surgery and treatment to her knees bilaterally were not associated with the multiple injuries which she described as job related and are secondary to the fall of September 6, 2002." He repeated his belief that the present symptoms in her low back and her knees bilaterally were secondary to the fall on September 6, 2002 and that they were not due to the previous back injury. This is in contrast to the reports of Dr. Katta, who generally supported that appellant's conditions were work related. For example, in a September 15, 2008 report, Dr. Katta diagnosed chronic cervical thoracic and lumbosacral sprain from a fall on October 3, 2007 and sprain of the right ankle and chronic lower back pain from degenerative disc disease and joint disease of both knees with tendinitis over medial aspect of both knees and RSD in both lower extremities.

A conflict now exists on the issue of whether appellant's claim should be expanded to include a consequential injury to her bilateral knees, lumbar spine and right elbow on September 6, 2002 and whether her claim should be expanded to include aseptic necrosis of the medial femoral condyle of the bilateral knees. FECA provides that, if there is disagreement between the physician making the examination for OWCP and the employee's physician, OWCP shall appoint a third physician who shall make an examination.[10]

[9] In the prior appeal, in a January 20, 2008 report, an OWCP medical adviser indicated that the medical evidence was insufficient to establish that appellant sustained injuries to her cervical spine, thoracic spine or shoulders on October 3, 2007. The Board also notes that, when Dr. Russell initially saw appellant in the prior claim, OWCP had not accepted the fall on September 5, 2002. OWCP subsequently indicated that this was accepted on May 20, 2010. *See supra* note 2.

[10] *Supra* note 8.

The Board will set aside OWCP's May 2, 2011 decision and remand the case for referral to an impartial medical examiner for further medical development pertaining to the issue of appellant's claim should be expanded to include a consequential injury to her bilateral knees, lumbar spine and right elbow on September 6, 2002 and whether her claim should be expanded to include aseptic necrosis of the medial femoral condyle of the bilateral knees. Following this and any such further development as may be deemed necessary, OWCP shall issue an appropriate final decision on whether appellant sustained appellant's claim should be expanded to include a consequential injury to her bilateral knees, lumbar spine and right elbow on September 6, 2002 and whether her claim should be expanded to include aseptic necrosis of the medial femoral condyle of the bilateral knees. Following such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the May 2, 2011 decision of Office of Workers' Compensation Programs is set aside and remanded.

Issued: August 27, 2012
Washington, DC

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

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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