U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of VERONICA GIBSON-BILLUPS and U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA

Docket No. 03-953; Submitted on the Record;
Issued June 19, 2003

DECISION and ORDER

Before COLLEEN DUFFY KIKO, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether appellant established that she sustained a left knee injury in the performance of duty on September 17, 2001.

On September 17, 2001 appellant, then a 41-year-old clerk, filed a notice of traumatic injury alleging that she experienced severe left knee pain that day as she was getting off a work stool to retrieve mail.[1] Appellant was seen that day at a local emergency room and diagnosed with left knee pain. She was prescribed medication and instructed to keep the knee immobilized and/or use crutches. The employing establishment offered appellant a limited-duty job effective September 19, 2001, which she accepted. The job allowed appellant to answer telephones in a sitting position with her left knee elevated as necessary.

In support of her claim, appellant submitted a copy of the discharge instructions from the University of Pennsylvania Hospital and a disability certificate dated September 18, 2001 from Dr. Earl Brown, a Board-certified family practitioner, who indicated that appellant was totally disabled for work from September 18 to October 1, 2001. Dr. Brown advised that appellant could return to regular light duty effective October 2, 2001. The diagnosis was torn meniscus of the left knee.

A magnetic resonance imaging (MRI) scan of the left knee dated September 24, 2001 revealed minimal medial joint effusion and mild degenerative arthritic changes.

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[1] On August 25, 1996 appellant sustained a left knee strain in the performance of duty and began working light duty. Appellant sustained a second work-related left knee injury on March 26, 1997, when she bent over to pick up some mail and experienced sharp knee pain. The Office of Workers' Compensation Programs accepted the claim for left knee strain and reflex sympathetic dystrophy with arthroscopic surgery. Appellant received appropriate compensation for wage loss from March 31, 1997 until she returned to part-time limited duty effective February 1, 1999.

In a report dated October 8, 2001, Dr. Jonathon C. Hersch, a Board-certified orthopedic surgeon, reported that appellant had a history of a left medial meniscus tear with arthroscopic surgery. He related that, following surgery, appellant continued to have medial joint pain with occasional locking and catching of the knee. Dr. Hersch further related that appellant had "a new injury on September 17, 2001" when she got up from a chair and felt sharp pain in her knee. Physical findings included medial tenderness and limited range of motion due to pain. The diagnosis was chronic left knee pain "mostly due to cutaneous nerve irritation, possibly from the infrapatella branches of the saphenous nerve." Dr. Hersch opined that this "could be from her prior injury or could be from an arthroscopic medial portal." He recommended an electromyographic (EMG) nerve conduction study to confirm a nerve injury. Dr. Hersch suggested that appellant could suffer from complex regional pain syndrome (CRPS) as it was considered to be one of the most common causes of an infrapatella saphenous nerve injury.

In an October 8, 2001 disability certificate, Dr. Hersch diagnosed left knee infrapatella branch saphenous neuroma and recommended EMG/nerve conduction velocity (NCV) testing.

In a disability certificate dated October 26, 2001, Dr. Brown indicated that appellant would be unable to return to work until November 30, 2001 due to her diagnosis of left knee pain.

In a letter dated November 21, 2001, the Office advised appellant of the factual and medical evidence required to establish her clam for compensation. Appellant was told to submit a reasoned medical opinion addressing how the mechanism of injury caused her medical problem and disability for work.

In a November 20, 2001 report, Dr. Deepak Mehrotra, a Board-certified anesthesiologist, advised Dr. Hersch that appellant had been examined at the pain clinic. There was no sensory deficit noted on examination of the left knee, but allodynia and hyperalgesia was found to be present in the left knee with some edema. The diagnosis was listed as CRPS with peripheral neuropathy. Dr. Mehrotra indicated that he planned to perform a lumbar sympathetic block to better evaluate the origin of appellant's pain.

In a report dated December 5, 2001, Dr. Margaret Zalewski, a Board-certified pain management specialist, indicated that she had examined appellant at the request of Dr. Brown. She discussed appellant's medical history of left knee pain and recorded physical findings. Dr. Zalewski's neurological examination revealed pain over the medial aspect of the left knee accompanied by sensory deficit, which was suggestive to her of saphenous neuropathy of the left side. She also noted strong signs of left carpal tunnel syndrome. An EMG/NCV was ordered for further evaluation.

In a December 10, 2001 statement, appellant described having to wear a leg brace for minor leg pain prior to the alleged September 17, 2001 work injury. She alleged that on September 17, 2001 when she slid off the stool and stood up she felt a very sharp pain in her left knee.

In a decision dated December 26, 2001, the Office denied compensation on the grounds that appellant failed to establish fact of injury. The Office specifically held that, while appellant

established an employment incident on the date alleged, she did not provide sufficient medical evidence to establish a causal relationship between the employment incident and her diagnosed condition.

In a January 7, 2002 letter, appellant requested an oral hearing.

Appellant underwent nerve conduction studies on January 9, 2002, which were within normal limits with no evidence of sensory neuropathy.

In a January 18, 2002 report, Dr. Mehrotra advised that appellant had undergone a lumbar sympathetic block on the left side with good relief in her pain following the procedure. He stated that he would repeat the procedure in four to six weeks and suggested that she follow a physical therapy regimen.

In a February 4, 2002 treatment note, Dr. Hersch indicated that appellant had pain on physical examination superficial to the left knee joint. He diagnosed appellant as suffering from "unfortunate chronic knee pain syndrome" of unknown anatomical etiology. Dr. Hersch did not feel that surgery was indicated and therefore directed appellant to follow up with pain management therapy.

In a progress report dated February 19, 2002, Dr. Hersch noted that appellant had a history of chronic left knee pain and had been referred for pain management. He indicated that there was no orthopedic intervention required at that time.

In a February 22, 2002 report, Dr. Mehrotra indicated that appellant continued to complain of left knee pain with CRPS and would require long-term management with the goal of making her as functional as possible.

In a decision dated August 5, 2002, an Office hearing representative affirmed the Office's December 26, 2001 decision.

On November 4, 2002 appellant requested reconsideration and submitted an additional report from Dr. Mehrotra dated October 14, 2002. He noted that appellant was initially seen at the pain center on November 2, 2001, at which time she complained of left knee pain that had been ongoing since her 1997 surgery. Dr. Hersch related that appellant wore a knee brace for edema in the left knee. Physical examination showed allodynia and hyperalgesia. In the left knee, there were no temperature or color changes. There was decreased sensation over the left knee. The patient was diagnosed with regional pain syndrome with neuropathy. The treatment plan included lumbar sympathetic blocks, pain medication, as well as adjunct medication with some success. Dr. Mehrotra stated as follows:

> "When acute pain is improperly or inadequately treated or there is peripheral nerve injury, the nervous system undergoes a structural reorganization. Although clinical healing may seem to have occurred, there are changes such as central and peripheral sensitization, wind up phenomena, NMDA receptor activation, sympathetic nervous system mediated pain generation and increase in the receptive field of the WDR neurons that occur in the nervous system.

"The result of these changes is that a minor nociceptive event or even the absence of such an event can trigger a perception of severe pain by the patient who has chronic pain.

"Therefore, acute and chronic pain is two different entities. Chronic pain patients are very little understood or sympathized with by the medical and nonmedical community alike. They are inappropriately labeled as psychogenic, malingerers and drug seekers.

"[Appellant] continues to be treated for a chronic pain condition, which can be difficult to manage. Her treatment plan will continue indefinitely into the future…."

In a November 27, 2002 decision, the Office denied modification of its prior decision.

The Board finds that appellant failed to establish that she sustained a left knee injury in the performance of duty on September 17, 2001.

An employee seeking benefits under the Federal Employees' Compensation Act[2] has the burden of establishing the essential elements of his or her claim including the fact that the individual is an "employee of the United States" within the meaning of the Act, that the claim was timely filed within the applicable time limitation period of the Act, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury.[3] These are essential elements of each compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[4]

In order to determine whether an employee has sustained a traumatic injury in the performance of duty, the Office begins with an analysis of whether a "fact of injury" has been established. There are two components involved in establishing fact of injury that must be considered. First, the employee must submit sufficient evidence to establish that she actually experienced the employment incident at the time, place and in the manner alleged.[5] Second, the employee must submit sufficient evidence, generally only in the form of medical evidence, to establish that the employment incident caused a personal injury.[6] The medical evidence required to establish a causal relationship, generally is rationalized medical evidence.[7]

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[2] 5 U.S.C. §§ 8101-8193.

[3] *Duane B. Harris*, 49 ECAB 248 (1997); *Joe D. Cameron*, 41 ECAB 153 (1989); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[4] *Dennis M. Mascarenas*, 49 ECAB 215 (1997); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[5] *Elaine Pendleton*, *supra* note 3.

[6] *Id*.

[7] *Ruby I. Fish*, 46 ECAB 276 (1994).

The Office found that, although appellant rose from a chair in the performance of duty on September 17, 2001 and felt severe left leg pain, she submitted insufficient medical evidence to establish a specific medical condition due to that employment incident. The Office noted that, while appellant had chronic left leg pain, there was no reasoned medical opinion to show a causal nexus between the left knee pain and the alleged September 17, 2001 work injury. Therefore, the Office found that appellant failed to establish fact of injury.

The Board agrees that the record lacks a reasoned medical opinion addressing the specific nature of appellant's alleged left knee condition on or after September 17, 2001. The Office properly advised appellant of her burden of proof to submit a reasoned opinion to support her claim for compensation.[8] Appellant, however, did not meet that burden of proof.

Although the reports from Dr. Hersch suggested the possibility of a nerve injury, that diagnosis was not confirmed by EMG testing. Moreover, Dr. Hersch did not offer an explanation as to how appellant suffered a nerve injury as a result of the simple action of arising from a chair. In his various reports, Dr. Hersch does no more than relate appellant's description of injury. He does not independently evaluate how appellant sustained an injury on September 17, 2001 nor does he provide a reasoned opinion on causal relationship between appellant's CRPS and the alleged work incident. The Board notes that, in his February 4, 2002 report, Dr. Hersch is unable to come up with any etiology for appellant's condition. In view of these inadequacies, Dr. Hersch's opinion is insufficient to carry appellant's burden of proof on causation.

Dr. Mehotra similarly fails to explain the origin of appellant's diagnosed chronic pain condition. His reports primarily discuss appellant's pain management treatment with lumbar sympathetic blocks. There is no reasoned opinion from Dr. Mehotra with regard to how appellant's chronic pain syndrome is related to the September 17, 2001 work injury.

The Board notes that appellant may have a pain syndrome causally related to her prior work injury or work factors, but she did not file either a claim for a recurrence of disability or a claim for occupational disease. Based on her claim for a traumatic injury on September 17, 2001, the Board finds insufficient evidence from which to conclude that appellant's diagnosed chronic left leg pain was causally related to her having risen from a chair in the performance of duty.

[8] The evidence required to establish a causal relationship is rationalized medical opinion evidence, based on a complete factual and medical background, showing a causal relationship between the claimed condition and the identified work factor. *Ronald C. Hand*, 49 ECAB 113 (1997).

The decision of the Office of Workers' Compensation Programs dated November 27, 2002 is hereby affirmed.

Dated, Washington, DC
June 19, 2003

Colleen Duffy Kiko
Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member