United States Department of Labor
Employees' Compensation Appeals Board

G.B., Appellant	)	
and	)	**Docket No. 09-712**
	)	**Issued: January 27, 2010**
U.S. POSTAL SERVICE, POST OFFICE, Pittsburgh, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On January 22, 2009 appellant filed a timely appeal from the May 5, 2008 and January 2, 2009 decisions of the Office of Workers' Compensation Programs that denied his claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this appeal.

ISSUE

The issue is whether appellant established that he sustained an ankle or hip condition as a consequence of his accepted osteoarthritis of the right knee or major depressive disorder.

On appeal, his attorney contends that the report of the impartial specialist failed to explain how appellant's work-related injury did not contribute in any way or to any degree to the claimed consequential conditions.

FACTUAL HISTORY

On January 27, 2005 appellant, then a 51-year-old retired mail handler, filed an occupational disease claim attributing degenerative joint disease of his right knee to walking,

standing, lifting mail and loading trucks in his federal employment. He first became aware of the disease on November 2, 2000 and of its relationship to his employment on January 7, 2005.[1] On February 16, 2006 the Office accepted that appellant sustained a permanent aggravation of osteoarthritis of his right knee.[2] Appellant elected to receive compensation benefits as of March 10, 2003 and was placed on the periodic rolls. On June 27, 2007 the Office accepted major depressive disorder as employment related.

On October 24, 2007 appellant, through his attorney, requested that his claim be accepted for consequential ankle and hip conditions. In an October 10, 2007 report, Dr. Gary L. Smith, an attending Board-certified orthopedic surgeon, noted that appellant developed severe arthritis of the right knee following a fracture and fracture management and complaints of discomfort in his ankle with weight-bearing activities. Because of the knee deformity, appellant had unusual stress on his ankle. Dr. Smith advised that a significant portion of appellant's ankle symptoms were related to a limp and awkward gait because of his deformed right knee. Appellant also had complaint of groin and buttock pain and symptoms of synovitis in the right hip which the physician also attributed to appellant's right knee condition. In an October 18, 2007 report, Dr. Smith advised that total knee arthroscopy had been scheduled on several occasions but that appellant had cancelled surgery.

On October 29, 2007 Dr. Arnold T. Berman, Board-certified in orthopedic surgery and an Office medical adviser, reviewed the medical evidence of record. He noted that a magnetic resonance imaging (MRI) scan demonstrated significant bulging discs at multiple levels of the lumbar spine.[3] This advanced lumbar spine pathology would be expected to have some radiation to the right hip area. Dr. Berman stated that there was no reason to believe that appellant would develop right hip pain from his knee abnormality. He attributed appellant's foot drop to a nonemployment-related proximal tibial fracture appellant sustained in August 1991. Dr. Berman found that appellant's right ankle and hip conditions should not be accepted as employment related.

On November 6, 2007 the Office referred appellant to Dr. Yram J. Gross, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a December 12, 2007 report, he reviewed of the medical record and appellant's history of treatment. Appellant complained of right knee pain, stiffness, locking and unsteadiness; right ankle pain with weakness and unsteadiness since a foot drop that developed three years prior; and pain over the lateral aspect of

[1] Appellant retired on disability effective January 7, 2005. Prior to his federal employment, on October 3, 1979 he had a work injury in which he fell 32 feet onto a factory roof injuring his wrists, ankles, both legs and spine. He had multiple fractures and several surgeries subsequent to this accident including a November 1988 left below knee amputation. In August 1991, appellant sustained a nonwork-related fracture of his right knee requiring open reduction internal fixation surgery of his proximal tibia. He was also in a nonoccupational motor vehicle accident on March 10, 2003 and had subsequent cervical disc surgery on May 13, 2003. Appellant stopped work in May 2003 and did not return.

[2] The Office had referred appellant to Dr. Stephen R. Bailey, a Board-certified orthopedic surgeon, who provided a February 8, 2006 report in which he advised that appellant's right knee was permanently aggravated by his employment duties and that he was totally disabled.

[3] An August 27, 2007 MRI scan of the lumbar spine demonstrated a very mild disc bulge at L2-3, a mild disc bulge at L3-4, a diffuse disc bulge at L4-5, and a mild diffuse disc bulge at L5-S1.

the right hip, which began one year prior. Physical examination revealed a slightly asymmetric gait with a left lower extremity prosthesis present. There was mild tenderness to palpation over the greater trochanter of the right hip. The right knee demonstrated valgus alignment with notable deformity and effusion with decreased range of motion and crepitance throughout. Appellant reported decreased sensation in the first web space and over the dorsum of the foot but not in a dermatomal distribution. Notable foot drop was present. Tibialis anterior and extensor hallucis longus were manually graded at 1/5, and gastroc soleus strength at 2/5.

An x-ray of the pelvis demonstrated no evidence of fracture or dislocation. X-ray of the right leg demonstrated marked valgus deformity and tricompartmental and patellofemoral end-stage degenerative changes. X-ray of the right ankle demonstrated overall normal alignment with no evidence of fracture, dislocation or subluxation. Dr. Gross diagnosed right knee end-stage post-traumatic arthritis, the result of the nonindustrial August 1991 injury with work-related aggravation; right lower extremity foot drop with subsequent ankle stiffness, not related to the right knee condition or factors of federal employment; and right hip pain, not related to the right knee condition or factors of federal employment. He found that appellant's foot drop was most likely related to the plateau fracture and its subsequent treatment, and the ankle stiffness most likely related to the chronic foot drop. Dr. Gross recommended right knee arthroplasty and stated once that appellant had been provided with adequate rehabilitation from knee reconstruction, he would be able to tolerate sedentary work.

The Office found a conflict in medical opinion arose between Dr. Smith and Dr. Gross as to whether appellant's right ankle and hip conditions were employment related.[4] It referred him to Dr. Michael J. Seel, a Board-certified orthopedic surgeon, for an impartial medical examination.

In a February 5, 2008 report, Dr. Seel reviewed the history of appellant's accepted right knee condition, medical treatment and a statement of accepted facts. He noted that appellant complained of pain to the right lateral hip, low back and right buttock. Dr. Seel noted a history of a nonemployment-related fall from a height in 1979 that ultimately resulted in a left below the knee amputation in 1989. On August 26, 1991 appellant was helping to move a washing machine that fell against his right leg and resulted in a proximal tibia fracture. He underwent an open reduction and internal fixation on August 27, 1991. Cervical spine surgery was performed in June 2003 and appellant had surgery on January 28, 2008 for a right total knee arthroplasty. Dr. Seel provided finding on physical examination, noting satisfactory varus and valgus stability, inability to dorsiflex the right lower extremity, and minimal inversion/eversion motion. The left lower extremity revealed the prosthesis in place. Dr. Seel stated that appellant's right lateral hip pain was due to probable trochanteric bursitis with a history of right foot drop. He noted that appellant's claim has been accepted for a permanent aggravation of osteoarthritis of the right knee. As appellant was 10 days post surgery, Dr. Seel anticipated that he would be able to return to light-duty work at three months following surgery. He advised that appellant's right hip and foot drop conditions were not employment related. Dr. Seel noted that appellant required care for his right knee condition consisting of physical therapy.

[4] On January 21, 2008 Dr. Smith performed a total right knee arthroplasty.

On February 20, 2008, Dr. Smith noted that appellant was progressing well following surgery. On March 27, 2008 he noted that when appellant got off crutches and went to a cane, he developed increased discomfort and swelling. Dr. Smith advised that x-rays of the knee components looked good and recommended continued therapy.

In a May 5, 2008 decision, the Office found that appellant's right ankle and hip conditions were not consequential to his employment injury.

On May 8, 2008 appellant, through his attorney, requested a hearing. However, a review of the written record was subsequently requested.

In a July 24, 2008 report, Dr. Smith advised that appellant was making a slow recovery from his right knee surgery. He stated that as a result of appellant's initial trauma to the right leg, he had a chronic nerve injury that caused weakness of the right ankle and foot that made him walk awkwardly and made the muscle pull on the ankle unevenly. Dr. Smith stated that physical examination revealed normal motion with tenderness over the hip abductors and some pain with resisted use but that x-rays showed no joint abnormality or arthritis. His clinical impression was that the pain was a hip tendinitis or bursitis and that this condition was not directly related to hip trauma but to limping caused by appellant's left leg amputation and right knee deformity. In a November 19, 2008 treatment note, Dr. Smith diagnosed total knee arthroplasty with continued stiffness and quad weakness. He noted that appellant was to get a new left knee prosthesis.

In a January 2, 2009 decision, an Office hearing representative affirmed the May 5, 2008 decision.

LEGAL PRECEDENT

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.[5] Regarding the range of compensable consequences of an employment-related injury, Larson notes that, when the question is whether compensability should be extended to a subsequent injury or aggravation related in some way to the primary injury, the rules that come into play are essentially based upon the concepts of "direct and natural results" and of the claimant's own conduct as an independent intervening cause. The basic rule is that a subsequent injury, whether an aggravation of the original injury or a new and distinct injury, is compensable if it is the direct and natural result of a compensable primary injury. Thus, once the work-connected character of any condition is established, the subsequent progression of that condition remains compensable so long as the worsening is not shown to have been produced by an independent nonindustrial cause.[6]

[5] *Mary Poller*, 55 ECAB 483 (2004).

[6] A. Larson, *The Law of Workers' Compensation* § 10.01 (November 2000).

A claimant bears the burden of proof to establish a claim for a consequential injury.[7] As part of this burden, he or she must present rationalized medical opinion evidence, based on a complete factual and medical background, showing causal relationship. Rationalized medical evidence is evidence which relates a work incident or factors of employment to a claimant's condition, with stated reasons of a physician. The opinion must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship of the diagnosed condition and the specific employment factors or employment injury.[8]

Section 8123(a) of the Act provides that if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[9] When the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based on a proper factual background, must be given special weight.[10]

ANALYSIS

The Board finds that appellant has not established that his right ankle or hip conditions are a consequence of the accepted aggravation of osteoarthritis of the right knee or major depressive disorder.

The Office accepted that appellant sustained a permanent aggravation of degenerative disease to his right knee and a major depressive disorder. Dr. Smith, an attending physician, advised that a significant portion of appellant' right ankle symptoms were related to the limp and awkward gait due to his deformed right knee. He also noted complaints in the groin, buttock and right hip synovitis which he attributed to the accepted right knee condition. Dr. Gross, a second opinion physician, reviewed appellant's history and diagnosed right knee end-stage degenerative changes, which he attributed to appellant's nonemployment-related injury in 1991. He found that appellant's right ankle condition was due to the right foot drop and not to the accepted aggravation of degenerative disease. Dr. Gross advised that appellant's right hip symptoms were not employment related. The Office properly referred appellant to Dr. Seel for an impartial medical examination based on the conflict arising between Dr. Smith and Dr. Gross.

Dr. Seel provided a February 5, 2008 report in which he extensively reviewed appellant's history of injuries to his right and left lower extremities and subsequent medical treatment. He advised that the 1979 fall from height resulted in the left knee amputation of 1989 and was not employment related. In 1991, appellant sustained a nonemployment-related fracture to the proximal tibia of the right leg and underwent open reduction surgery. Dr. Seel noted that appellant's arthritis of the right knee was subsequently accepted as employment related. He provided findings on physical examination, noting that appellant was 10 days post surgery for a

[7] *J.J.*, 60 ECAB ___ (Docket No. 09-27, issued February 10, 2009).

[8] *Charles W. Downey*, 54 ECAB 421 (2003).

[9] 5 U.S.C. § 8123(a); *see Geraldine Foster*, 54 ECAB 435 (2003).

[10] *Manuel Gill*, 52 ECAB 282 (2001).

right total knee arthroplasty. Dr. Seel found that appellant's right lateral hip pain was due to trochanteric bursitis, a condition that was not causally related to appellant's former federal employment. He also noted that appellant's right foot drop and ankle conditions were not work related. Dr. Seel advised that appellant did not require further medical care for his accepted right knee condition as he had recently undergone total knee replacement.

The Board finds that the report of Dr. Seel, the impartial medical specialist, constitutes the weight of medical opinion. He provided a thorough review of the medical evidence and based his opinion on a comprehensive examination of appellant's right lower extremity.

Following examination by Dr. Seel, appellant submitted additional evidence from Dr. Smith who reported on appellant's recovery from right knee replacement surgery and stated that, as a result of his initial right leg trauma in 1991, appellant had a chronic nerve injury that caused weakness to the right ankle and foot. Dr. Smith appeared to revise his opinion as to appellant's right hip condition, noting that x-rays showed no joint abnormality or arthritis. His impression was hip tendinitis or bursitis not related to hip trauma but by limping due to appellant's left leg amputation and right knee deformity. The Board notes that the additional evidence from Dr. Smith is not sufficient to establish that appellant's right hip or ankle conditions were caused or contributed to by his federal employment. Dr. Smith did not adequately explain how the aggravation of appellant's right knee arthritis would produce tendinitis or bursitis to the right hip. As noted, the right hip x-rays which Dr. Smith reviewed did not show any joint abnormality or arthritis. In this regard, Dr. Smith supported the diagnosis of bursitis as noted by Dr. Seel. The record reflects that appellant has significant injury to both lower extremities. The medical evidence, however, does not establish his right hip or ankle conditions as related to his former federal service as a mail handler.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish that his right hip or ankle conditions are a consequence of the accepted permanent aggravation of osteoarthritis to the right knee.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated January 2, 2009 and May 5, 2008 be affirmed.

Issued: January 27, 2010
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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