

FACTUAL HISTORY

This case was previously before the Board.³ Appellant, a 64-year-old former transportation security screener, has an accepted occupational disease claim for lumbar spinal stenosis and bilateral leg sprains which arose on or about March 2, 2006.⁴ He attributed his injury to lifting baggage at a checkpoint area over a 12-week period. OWCP approved a March 15, 2007 laminectomy at L4-5 and an April 2, 2007 L4-5 anterior lumbar interbody fusion. On August 20, 2007 appellant underwent a right knee arthroscopic procedure, which OWCP authorized under claim number xxxxxx871.⁵ He resumed work on August 28, 2007 as a driver's license examiner for the Tennessee Department of Safety, a position he had held since August 2006. When he returned to work in August 2007, appellant accepted a 90-day modified assignment which was scheduled to expire on November 28, 2007. Once the 90-day period ended, the employing establishment decided against retaining his services. Appellant, therefore, filed a claim for wage-loss compensation (Form CA-7) with respect to his March 2, 2006 employment injury.⁶ He also filed a claim for a schedule award.

By decision dated March 12, 2008, OWCP denied appellant's claim for temporary total disability (TTD) on or after November 28, 2007. On March 25, 2008 it issued a decision denying his claim for a schedule award. When the case was last on appeal, the Board affirmed both decisions.⁷ OWCP has since expanded appellant's claim to include acute respiratory failure as an accepted condition.⁸ Also, it paid wage-loss compensation for TTD beginning November 14, 2008 and placed him on the periodic compensation rolls effective March 15, 2009.

OWCP authorized additional lumbar surgery, which was performed on May 11, 2009.⁹ Following his latest surgery, appellant continued to experience low back and right lower extremity pain. In September 2009, his surgeon referred him to Dr. William H. Leone, a Board-

³ Docket Nos. 08-1351 & 08-1355 (issued November 7, 2008).

⁴ Appellant previously sustained an employment-related right knee strain on February 3, 2004 claim number (xxxxxx815). He also injured his right knee on July 29, 2005, which OWCP accepted for right medial meniscus tear claim number (xxxxxx871). Additionally, OWCP authorized right knee arthroscopic surgery which was performed on September 29, 2005.

⁵ OWCP subsequently closed appellant's July 29, 2005 right knee claim number (xxxxxx871) and included the previously accepted right medial meniscus tear under the current claim number (xxxxxx368).

⁶ Appellant was already receiving compensation for a loss of wage-earning capacity due to his July 29, 2005 right knee injury claim number (xxxxxx871).

⁷ The Board's October 7, 2008 decision is incorporated herein by reference.

⁸ On November 14, 2008 appellant was being treated in the emergency room (ER) for extreme back pain. While in the ER, he stopped breathing and was placed on a respirator. Appellant's acute respiratory failure was attributed to Ativan (benzodiazepine) he received in the ER and central alveolar hypoventilation.

⁹ Dr. Richard A. Berkman, a Board-certified neurosurgeon, performed a laminectomy and facetectomy at L2-3 and L3-4 with removal of previous scar cicatrix. Additionally, he removed pedicle screws at L4-5. Dr. Berkman was also responsible for appellant's two prior lumbar surgeries in March and April 2007.

certified anesthesiologist specializing in pain management. Dr. Leone treated appellant from October 2009 through February 2011, at which time appellant relocated from Tennessee to Arkansas. Dr. Leone's latest diagnosis was lumbar radiculopathy and lumbar postlaminectomy syndrome.

Dr. Michael R. Stone, a Board-certified anesthesiologist with a subspecialty in pain medicine, began treating appellant on May 6, 2011. He noted that appellant was initially injured on March 2, 2006 while working for the employing establishment. Dr. Stone examined appellant and reviewed previous medical records, which included various operative reports and magnetic resonance imaging (MRI) scans of the cervical and lumbar spine. His initial diagnosis was lumbar radiculopathy, failed back syndrome and lumbar neuropathy. Appellant saw Dr. Stone again on June 10, 2011 and had another follow-up appointment on September 23, 2011. Dr. Stone's September 23, 2011 physical examination findings included, *inter alia*, right foot drop with some numbness of the right leg. He continued to diagnose lumbar radiculopathy, failed back syndrome and lumbar neuropathy. Dr. Stone advised appellant to return in four months. When he next saw appellant on January 6, 2012, he reported that appellant was using a cane and had right foot drop. Physical examination also revealed that appellant was unstable with his walking and was tender at L4-5 and L5-S1. Dr. Stone again diagnosed lumbar radiculopathy, failed back syndrome and lumbar neuropathy. Appellant was to continue his current medications, which included hydrocodone, Lyrica and Ambien.

Appellant continued to see Dr. Stone every three to four months. Dr. Stone's March 2, June 22 and September 28, 2012 treatment notes consistently reported findings of right foot drop on physical examination. He continued to diagnose lumbar radiculopathy, failed back syndrome and lumbar neuropathy.

When appellant returned on December 28, 2012, he continued to complain of low back and right leg pain. Dr. Stone noted that appellant previously had right leg bracing, which recently broke. On physical examination, he noted that appellant's right foot drop was prominent and that he walked with a cane. Dr. Stone also noted that appellant was having difficulty with stumbling. Appellant's lumbar area was mostly nontender and he had positive straight leg raise at about 10 degrees on the right. Dr. Stone diagnosed lumbar radiculopathy, failed back syndrome, lumbar neuropathy and foot drop, with dragging foot on the right. He increased appellant's hydrocodone dosage to help with his pain and recommended bracing to help with his foot drop. Dr. Stone explained that appellant had a dragging foot that made him unstable and more apt to fall. He reported similar findings on March 8, 2013. Dr. Stone added that he was having difficulty contacting OWCP regarding the recommended bracing to help with appellant's foot drop, noting that he continued to walk with instability.

On March 13, 2013 OWCP advised appellant that it received notification of a possible consequential condition of right foot drop in relation to his March 2, 2006 employment injury. It further advised that Dr. Stone's December 28, 2012 report was insufficient to establish that the condition was causally related to the accepted injury, treatment received or any of the accepted medical conditions. The letter included instructions for Dr. Stone regarding the required medical evidence, as well as a statement of accepted facts. OWCP afforded appellant 30 days to submit the requested information.

In a March 23, 2013 response, Dr. Stone explained that he treated appellant for lumbar spine and leg pain, as well as right foot drop. While he started seeing appellant in 2011, he noted that the initial injury occurred five years earlier in 2006. Dr. Stone also reported that appellant continued to have right foot drop. Additionally, he indicated that appellant's brace was broken and that he continued to try to get a new leg bracing system for him. Dr. Stone further noted that foot drop had been present for several years before he first saw appellant. He stated that the condition was related to appellant's back pathology as evident on MRI scan. However, Dr. Stone indicated that this occurred years before appellant became his patient. He reiterated his diagnoses of lumbar radiculopathy, failed back syndrome, foot drop and lumbar neuropathy.

In an April 17, 2013 report, the district medical adviser (DMA) noted his disagreement with appellant's treating physician regarding the diagnosis of right foot drop. He noted that Dr. Stone had not done any muscle testing of the right or left toes, foot or ankle and had not measured the girth of appellant's right leg in comparison to his left. The DMA also reviewed other medical reports and commented that the medical records did not show on a clinical basis that appellant had right foot drop. He found that there was no medical basis to accept right foot drop as being consequential to the conditions already accepted by OWCP.

In follow-up treatment notes dated June 7 and August 16, 2013, Dr. Stone continued to diagnose lumbar radiculopathy, failed back syndrome, lumbar neuropathy and foot drop.

OWCP referred appellant to Dr. William F. Blankenship, a Board-certified orthopedic surgeon, to determine whether he had right foot drop.¹⁰ Dr. Blankenship examined appellant on August 20, 2013 and reviewed various medical records. He noted a history of injury lifting bags on March 2, 2006. Dr. Blankenship also noted that appellant had undergone two lumbar surgeries in 2007 and another surgical procedure in April 2009. Appellant reportedly advised Dr. Blankenship that he had right foot drop problems since the original onset in 2006. On physical examination Dr. Blankenship noted that appellant had a tremor while sitting in the examination room. Appellant's right foot was in inversion and plantar flexion. Examination of the right foot revealed some decreased skin temperature and hyperemia. Dr. Blankenship noted that he did not see any skin distribution changes in the right foot as compared to the left foot, nor in hair or nail. Appellant reportedly commented that the hair on his left leg grew faster than on the right. Dr. Blankenship also noted that, as appellant stood in an unknown position, his right foot went out of the inverted position and became more plantar grade. He further commented that examination of the right foot revealed no excessive callus formation in relation to the left foot. Additionally, Dr. Blankenship noted that there was no muscle activity whatsoever to attempt to move the right foot from the held inverted plantar flexed position. Knee jerks were

¹⁰ OWCP previously referred appellant to Dr. Thomas P. Rooney and Dr. Kenneth M. Rosenzweig, both of whom are Board-certified orthopedic surgeons. Dr. Rooney examined appellant on August 31, 2011 and recommended additional testing, which included electromyography and nerve conduction studies, a whole body bone scan and computerized tomography angiography of the abdomen and lower extremities. Dr. Rosenzweig subsequently examined appellant on August 24, 2012. Although their respective reports included findings regarding appellant's lower extremities, at the time OWCP focused its inquiry on his ability to return to work and had not specifically requested that either physician address the cause and/or extent of appellant's claimed right foot drop. In fact, OWCP's referral to Dr. Rooney predated Dr. Stone's initial September 23, 2011 finding of right foot drop. Because OWCP's prior development did not focus on the issue of right foot drop, OWCP subsequently referred appellant to Dr. Blankenship to address this particular condition.

normoactive and equal bilaterally. There was an ankle jerk on the left, but Dr. Blankenship reportedly could not get an ankle jerk on the right. He attributed this in part to the positioning of appellant's right foot and ankle. Dr. Blankenship also noted that there were pulses in both feet. Appellant's left and right thigh both measured 40 centimeter (cm). His left calf measured 43 cm, whereas his right calf measured only 40 cm. Dr. Blankenship commented that appellant had two knee surgeries on the right side. He further noted that examination of the lumbar spine revealed a well-healed incisional scar in the lower portion of the spine. Flexion was approximately 65 degrees and hyperextension was neutral.

After describing his own examination findings, Dr. Blankenship provided a synopsis of the various medical reports and records he reviewed. He then diagnosed lumbar stenosis/spinal stenosis and status post three surgical procedures. In response to OWCP's question of whether appellant had a consequential work-related right foot drop condition, Dr. Blankenship stated that there was no objective evidence that appellant had drop foot as a result of his work-related injury.

In a September 25, 2013 decision, OWCP found that appellant had not established that his claimed right foot drop was causally related to the March 2, 2006 employment injury, the accepted medical condition(s) or any authorized medical treatment, including OWCP-approved lumbar surgeries.

LEGAL PRECEDENT

Where an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.¹¹

When an injury arises in the course of employment, every natural consequence that flows from that injury likewise arises out of the employment, unless it is the result of an independent intervening cause attributable to claimant's own intentional misconduct.¹² Thus, a subsequent injury, be it 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.¹³

ANALYSIS

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

¹¹ *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004). Causal relationship is a medical question, which generally requires rationalized medical opinion evidence to resolve the issue. See *Robert G. Morris*, 48 ECAB 238 (1996). A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factors must be based on a complete factual and medical background. *Victor J. Woodhams*, 41 ECAB 345, 352 (1989). Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factors. *Id.*

¹² *Mary Poller*, 55 ECAB 483, 487 (2004); 1 Arthur Larson & Lex K. Larson, *Larson's Workers' Compensation Law* 10-1 (2006).

¹³ *Susanne W. Underwood (Randall L. Underwood)*, 53 ECAB 139, 141 n.7 (2001).

Appellant's physician, Dr. Stone, consistently reported findings of right foot drop on physical examination dating back to September 23, 2011. In his March 23, 2013 report, Dr. Stone attributed appellant's right foot drop to his employment-related back pathology. He noted that foot drop had been present for several years before he first saw appellant in May 2011. In an April 17, 2013 report, the DMA disagreed with Dr. Stone regarding the diagnosis of right foot drop. OWCP then referred the case to Dr. Blankenship for a second opinion evaluation. Dr. Blankenship examined appellant on August 20, 2013 and also reviewed various medical records. His report included, a four-page synopsis of the medical records he reviewed. Based on his examination and review, Dr. Blankenship diagnosed lumbar stenosis/spinal stenosis and status post three surgical procedures and found no objective evidence that appellant had drop foot as a result of his work-related injury.

In its September 25, 2013 decision, OWCP did not specifically rely on Dr. Blankenship's August 20, 2013 report, but instead noted the absence of any well-reasoned medical opinion establishing that a right foot drop condition was causally related to appellant's March 2, 2006 employment injury.

While the burden lies with appellant to establish entitlement to benefits, once OWCP undertakes development of the record, it must do a complete job in procuring medical evidence that resolves the relevant issues in the case.¹⁴ Dr. Stone's various reports did not satisfy appellant's burden. Dr. Blankenship performed a second opinion examination for OWCP. However, his report did not adequately explain how he arrived at his findings. Dr. Blankenship provided a brief description of his physical examination findings and a four-page synopsis of appellant's medical records.¹⁵ The Board finds that Dr. Blankenship's report is insufficient. Dr. Blankenship does not explain how the medical records and physical examination demonstrate the absence of right-sided foot drop, which is causally related to appellant's accident. OWCP should seek further information and clarification from Dr. Blankenship.¹⁶ Accordingly, the case is remanded for further development. After OWCP has developed the record to the extent it deems necessary, a *de novo* decision shall be issued.

CONCLUSION

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

¹⁴ *Richard F. Williams*, 55 ECAB 343, 346 (2004).

¹⁵ Noticeably absent from this synopsis was any reference to Dr. Stone's March 23, 2013 opinion.

¹⁶ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *OWCP Directed Medical Examinations*, Chapter 3.500.3f(2)(a) (July 2011).

ORDER

IT IS HEREBY ORDERED THAT the September 25, 2013 decision of the Office of Workers' Compensation Programs is set aside. The case is remanded for further action consistent with this decision of the Board.

Issued: April 17, 2014
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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