U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of EUGENIA SMITH and U.S. POSTAL SERVICE,
POST OFFICE, Baton Rouge, LA

Docket No. 99-754; Submitted on the Record;
Issued April 23, 2001

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,
BRADLEY T. KNOTT

The issue is whether appellant has met her burden of proof to establish entitlement to medical benefits.

On November 2, 1986 appellant, a distribution clerk, injured her left knee and hand when she slipped and fell in the performance of duty. The claim was accepted for a left knee chrondomalacia and a torn meniscus of the left knee, along with consequential conditions including a torn meniscus of the right knee and a left heel spur. Appellant underwent arthroscopic surgery for her left knee on May 8, 1987, September 27, 1988 and March 12, 1992. She also had exploration of the saphenous nerve and removal of a lipoma from her left knee on June 23, 1993. Appellant received compensation for wage loss and returned to work for three hours per day on March 26, 1990.

In a decision dated May 14, 1998, the Office of Workers' Compensation Programs refused to pay for medical benefits related to appellant's treatment for a sacroiliac condition and reflex sympathetic dystrophy (RSD) on the grounds that those conditions were not causally related to appellant's work-related injury of November 2, 1986.

On August 6, 1998 appellant requested reconsideration.

In a decision dated September 29, 1998, the Office denied modification following a merit review.

The Board finds that the case is not in posture for decision.[1]

[1] The Board does not have jurisdiction to review, for the first time on appeal, evidence that was submitted subsequent to the Office's final decision on September 29, 1998; *see* 20 C.F.R. § 501.2(c).

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 the essential elements of each and every claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[4] As part of this burden, the claimant must present rationalized medical evidence, based upon a specific and accurate history.[5] Rationalized medical evidence is evidence which relates a work incident to a claimant's condition, with stated reasons of a physician.[6]

Medical benefits are provided for under section 8103 of the Act which states:

> "(a) The United States shall furnish to an employee *who is injured while in the performance of duty*, the services, appliances, and supplies prescribed or recommended by a qualified physician, which the Secretary of Labor considers likely to cure give relief, reduce the degree or the period of disability, or aid in lessening the amount of monthly compensation." (Emphasis added.) 5 U.S.C. § 8103.

In order to be entitled to reimbursement of medical expenses, appellant must establish that the expenditures were incurred for treatment of the effects of an employment-related injury. Proof of causal relation must include supporting medical rationale.[7] The issue presented in this case is whether appellant submitted sufficient medical evidence to carry her burden of proof in establishing her entitlement to reimbursement of medical expenses related to her diagnosed sacroiliac condition and RSD.

In a report dated September 15, 1992, Dr. Richard H. Gold, a Board-certified neurologist, noted that appellant had a "pelvic tilt" and that she was very tender over the sacroiliac joint on the left side. He opined that appellant had "sacroiliac joint discrepancy" that was related to appellant "favoring" her knee.

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[2] 5 U.S.C. §§ 8101-8193.

[3] *Elaine Pendleton*, 40 ECAB 1143 (1989).

[4] The Office's regulations clarify that a traumatic injury refers to injury caused by a specific event or incident or series of events or incidents occurring within a single workday or shift, whereas an occupational disease refers to injury produced by employment factors which occur or are present over a period longer than a single workday or shift; *see* 20 C.F.R. §§ 10.5(a)(15), (16).

[5] *Joseph T. Gulla*, 36 ECAB 516 (1985).

[6] *Debra A. Kirk-Littleton*, 41 ECAB 703 (1990); *Edgar L. Colley*, 34 ECAB 1691, 1696 (1983).

[7] *Delores May Pearson*, 34 ECAB 995 (1983).

Dr. Gold subsequently ordered a computerized tomography (CT) scan of the sacroiliac region on October 9, 1992. The interpretation of the CT scan was that "symmetric sclerosis of the bilateral sacroiliac joints was probably a developmental variant of normal."

In order to ascertain whether there was a causal relationship between appellant's sacroiliac condition and her work injury, the Office referred appellant for an evaluation with Dr. Robert A. Steiner, a Board-certified orthopedic surgeon. In a report dated November 3, 1992, he stated that appellant's lumbar vertebrae were within normal limits. X-rays of the pelvis were reviewed and showed no abnormalities involving the hips and sacroiliac joints, no degenerative changes, no fractures or areas of bony destruction. Dr. Steiner concluded that there was no definitive evidence that appellant's complaints regarding the left side of her lower back were related to her work injury.

In a report dated December 11, 1992, Dr. Edan M. Doyle, a Board-certified physician in physical medicine and rehabilitation, indicated that appellant had been examined at the request of the Office on November 19, 1992.[8] She noted appellant's history of injury on November 2, 1986 and subsequent medical treatment. Dr. Doyle reported physical findings and symptoms. She opined that appellant hurt her sacroiliac joint in the fall on her left knee as the force of the fall was transmitted up the femur to the pelvis. Her diagnoses included: (1) sacroiliac dysfunction with the left locked and posterior and muscle imbalance syndrome; and (2) left knee dysfunction with quadriceps, patellar and pes anserinus tendinitis and irritation of the medical femoral branch of the saphenous nerve. Dr. Doyle recommended that appellant undergo physical therapy for the sacroiliac program and injections for the tendinitis. She further stated:

> " A block of the saphenous nerve ... would greatly diminish [appellant's] pain and with decreased pain she would more amenable to range of motion. It is most important for a person to be able to flex the knee to 90 degrees in order to stand correctly ... she can only flex to 82 degrees. The 20 degree lack of extension means that she is leaning to that side when walks she and this is effecting her sacroiliac joint."

In an October 11, 1996 report, Dr. Edwin C. Simonton, an Office referral physician and Board-certified orthopedic surgeon, opined that appellant "made no complaints which would cause an examiner to be suspicious of [RSD]." He reported on physical examination that appellant had no signs of that condition and that she only demonstrated a slight hypersensitivity over the medial surface of the left knee, with normal neurological findings in the lower extremities.

In a September 25, 1997, Dr. Donna Holder, a Board-certified anesthesiologist who specializes in pain management, stated that RSD was causing some of the problems with appellant's left knee including her symptoms of burning pain, pins-and-needles sensation, hyperesthesia, coldness and sensitivity to extremes of temperature. She noted that appellant's anxiety level was extremely high as reported on a baseline psychological screen. Dr. Holder recommended that appellant undergo further psychometric testing prior to proceeding with a lumbar sympathetic block.

[8] This examination was conducted in conjunction with appellant's claim for a schedule award.

In an April 16, 1998 report, Dr. Baer I. Rambach, a Board-certified orthopedic surgeon, reported that appellant complained of pain and discomfort in both lower extremities, that she used a cane to walk and was unable to put any weight on her left leg. He noted that appellant was previously diagnosed with RSD in the left leg. On physical examination, he noted that appellant had some superficial varicosities in the right leg, which he felt were responsible for appellant's right leg pain. Dr. Rambach recommended that appellant see a vascular surgeon for treatment of varicose veins and that she continue her pain management treatment with Dr. Holder related to RSD in the left leg.

In a June 9, 1998 report, Dr. Rambach reiterated that it was Dr. Holder who diagnosed that appellant suffered from RSD in the left lower extremity and that RSD is a clinical diagnosis with no objective test to confirm the condition. Dr. Rambach further noted Dr. Holder's opinion that RSD was common following surgery on the saphenous nerve. He recommended that appellant have an MRI scan of the right knee as she continued to have balance and buckling problems with the right knee that he did not feel was associated with RSD.

In a July 7, 1998 report, Dr. Rambach indicated that appellant had a tear of the posterior horn of the medial meniscus in the right knee according to an MRI scan performed on June 16, 1998. He advised that there was no RSD of the right knee detected.

The Board finds that a conflict exists in the record between the opinion of appellant's treating physician, Dr. Gold and the Office referral physician, Dr. Steiner, as to whether appellant suffers from a sacroiliac joint dysfunction.[9] There is also a conflict in the record between Drs. Holder and Rambach, who agree that appellant has RSD, and the Office referral physician, Dr. Simonton who disputes the diagnosis of the condition.

Section 8123(a) of the Act provides that, if there is disagreement between the physician making the examination for the United States and physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[10] On remand, the Office should refer appellant, along with a statement of accept facts and a copy of the medical record, to a Board-certified physician for an impartial medical evaluation. After further medical development as the Office deems necessary, the Office shall issue a *de novo* decision.

[9] Although Dr. Gold's opinion was contradicted somewhat by an MRI scan, it was also corroborated by the report of Dr. Doyle, who also examined appellant at the request of the Office.

[10] 5 U.S.C. § 8123(a); *Wen Ling Chang*, 48 ECAB 272 (1997).

The decision of the Office of Workers' Compensation Programs dated May 14, 1998 is hereby vacated and the case is remanded for further consideration consistent with this opinion.

Dated, Washington, DC
April 23, 2001

Michael J. Walsh
Chairman

David S. Gerson
Member

Bradley T. Knott
Alternate Member