U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of LYNN LeVASSEUR and DEPARTMENT OF THE AIR FORCE, LORING AIR FORCE BASE, Caribou, ME

Docket No. 03-278; Submitted on the Record;
Issued September 2, 2003

DECISION and ORDER

Before COLLEEN DUFFY KIKO, DAVID S. GERSON, WILLIE T.C. THOMAS

The issues are: (1) whether the Office of Workers' Compensation Programs properly rescinded its acceptance of appellant's right knee condition; and (2) whether the Office met its burden of proof in terminating appellant's compensation.

On November 2, 1993 appellant, then a 47-year-old quality control inspector, filed a notice of traumatic injury and claim for compensation (Form CA-1), alleging that she slipped on snow covered steps and landed on her outstretched arms. She got up and slipped again, landing on her buttocks. In a November 2, 1993 report, Dr. Gregory Cochran, an emergency room physician, wrote that appellant presented in no apparent distress and ambulated without difficulty. He diagnosed appellant with a low back sprain. In a November 8, 1993 note, Dr. Carole St. Pierre-Engels, an orthopedist, wrote that appellant presented her with complaints of pain radiating down her back and into her right leg. X-rays showed a narrow disc space over the entire lumbar region especially L2-3. She diagnosed appellant with persistent severe back strain. In a November 29, 1993 progress note, Dr. Daniel Harrigan, a specialist in emergency medicine, wrote that appellant had low back strain with bulging discs and recommended that she not work. In a December 10, 1993 form report, Dr. Harrigan, diagnosed appellant with right sciatica with bulging discs at L4-5 and S1. In a December 27, 1993 decision, the Office accepted appellant's claim for low back strain and she received total temporary disability.

In a February 11, 1994 report, Dr. Jean-Pierre Michaud, an orthopedic surgeon, noted that appellant was two months pregnant, had a history of back problems and had experienced constant bilateral leg pain since the November 2, 1993 fall. In a March 17, 1994 report, Dr. Rodney Rozario, a neurologist, diagnosed her with a disc bulge at L4-5 and L5-S1 without herniation and no lumbar radiculopathy. An April 13, 1994 magnetic resonance imaging (MRI) scan of the lumbar spine was unremarkable. Appellant remained on total temporary disability due to pain.

In a May 23, 1994 letter, appellant was referred for a second opinion to Dr. Gary Parker, an orthopedist. In a March 1, 1995 report, Dr. Parker indicated that appellant had midline

tenderness in the lumbosacral region. Appellant tended to co-contract and become very tremulous when asked to flex, extend laterally and bend to either side and to rotate to either side in the lower back region. Dr. Parker found the neurological evaluation of her lower extremities normal. Straight leg raising was normal. Dr. Parker reviewed lumbosacral x-rays, computerized tomography (CT) scan and an MRI scan of the lumbosacral region and found them all normal. He diagnosed appellant with chronic lumbosacral dysfunction-fibromyalgia, type symptoms and extensor muscle deconditioning syndrome.

In a May 3, 1995 report, Dr. Parker added to appellant's diagnosis a neck and arm strain and prepatellar bursitis in her right knee that he attributed to the physical therapy sessions. She remained off work due to pain.

In a February 23, 1996 report, Dr. Roger T. Pelli, an osteopath, who practices family medicine, diagnosed appellant with somatic dysfunction of the cervical and thoracic spine, myofascial pain syndrome left neck and upper thoracic area and carpal tunnel syndrome in her left wrist. In a May 17, 1996 progress note, he wrote that she was doing better with her carpal tunnel syndrome and the somatic dysfunction in her back. Dr. Pelli added to her diagnosis possible manic-depressive disorder.

In a June 29, 1996 report, Dr. Pelli added that appellant had a snapping and locking sensation in her right knee. He feared an internal derangement of the knee and requested an MRI scan or arthroscopic surgery for her knee.

In an October 21, 1996 report, Dr. Pelli wrote that appellant said that at the time of the initial injury her legs slid underneath a parked vehicle and she heard a snap and felt pain in her right knee. Since that time appellant said that she had experienced a clicking sensation in the right knee when walking and more recently numbness over the lateral aspect of the knee. Dr. Pelli said that the right knee pain was ignored at the time of the original injury due to the intense pain in her neck and back. He added that it was conceivable and not unlikely that the knee injury occurred in the 1993 fall; and because cartilaginous injuries do not repair themselves, the symptoms will persist indefinitely until corrected.

In an April 11, 1997 report, Dr. Pelli wrote that appellant reported falling and injuring her right knee on April 2, 1997, when she slipped while stepping out of her husband's truck. The fall resulted in swelling and pain especially in the suprapatellar area, with pain worsening with weight bearing and flexion and extension of the knee. He indicated that appellant has ongoing pain in the right knee with questionable internal derangement that had not been worked up. Dr. Pelli continued to treat appellant's somatic dysfunctions and chronic neck and back pain syndrome.

On May 8, 1997 appellant was referred for a second opinion to Dr. James Lawsing, an orthopedist. In a May 15, 1997 report, Dr. Lawsing wrote that appellant described the original injury as resulting from two falls on ice and sliding underneath a parked vehicle. Appellant described her present concerns related to the pain in her right knee and hip. She said her back had not bothered her for a year. Dr. Lawsing diagnosed: (1) L3 radiculopathy right by electromyogram (EMG) with bilateral disc herniation L3-4 to the left; (2) right sciatica clinically

S1 and L3; (3) rule out internal derangement lateral meniscus right knee; and (4) right knee prepatellar bursitis.

Regarding appellant's knee, Dr. Lawsing wrote:

> "The right knee condition is unclear with regards to [appellant's] injury of November 2, 1993. [She] does describe sliding under her vehicle and banging her knee and it is conceivable that her prepatellar bursa is related to this. It was not picked up due to her subsequent pregnancy. With regards to the soreness in the lateral joint line, it is hard to relate this specifically to the injury of November 2, 1993, although this is a possibility given the mechanism of sliding underneath the vehicle. There is no description of this in any of the previous records. Based on the history and the records reviewed, the only residual I can tie to [appellant's] knee would be the prepatellar bursitis. This does not eliminate the fact [that] she may have a problem with her lateral meniscus. This may have been masked by [appellant's] leg pain that was related to her back. She still has some lateral numbness related to her back.

In a September 2, 1998 report, Dr. Patrick Fallon, an orthopedic surgeon, wrote that appellant indicated that she had right knee pain for five years after falling and sliding underneath a vehicle. He diagnosed degenerative meniscal tears, medial and lateral of right knee.

In an October 1, 1998 letter, the Office accepted right knee strain and authorized arthroscopic surgery that was performed on October 8, 1998. In the follow-up report to the surgery, Dr. Fallon diagnosed chondromalacia in Grade 2 and 3 medial and lateral femoral condyle.

In a February 16, 1999 report, Dr. Pelli diagnosed appellant with left facial numbness in left upper extremity of questionable etiology, knee pain of questionable etiology and somatic dysfunction of the thoracic and lumbar spine. In a July 14, 1999 report, Dr. Stephen Klein a neurologist and second opinion referral, wrote that appellant complained of numbness involving the left side of her face in addition to the left upper extremity; it started five years ago and has increased over the past five months. The numbness primarily involved the left face and upper extremity, although it involved the left third, first and second digits. He found that the numbness was unrelated to any position of her neck or upper extremity. Appellant also complained of pain in her low back and buttock near the midline of the low lumbosacral junction. She also indicated that she was depressed.

Based on objective criteria Dr. Klein found that appellant had a completely normal examination. He wrote that appellant's complaints blossomed to include areas of her body not injured at the time of her accepted fall and that clearly her complaints, other than that of low back pain and perhaps her right leg, bear no relationship to her accepted injury.

Dr. Klein found that appellant suffered no residual effects and had a normal work capability with the possible exception of her right knee, which he deferred to her orthopedist, due to his lack of expertise in that area. He recommended no further diagnostic studies and with the exception of her right knee complaints, no further treatment whatsoever.

In an August 6, 1999 letters, the Office proposed rescinding acceptance of the knee condition and the authorization for surgery and terminating appellant's compensation. The basis of the rescission was that appellant did not report a knee condition until April 1997, after she fell from her husband's truck.

In a September 3, 1999 request for reconsideration, appellant's representative argued that the record had numerous references to appellant's knee condition prior to the April 1997 fall.

In a September 16, 1999 letter, the Office referred appellant for a second opinion, to Dr. Phillip Anson, an orthopedist. There is no report from him in the record.[1]

In a May 31, 2000 report, Dr. James Curtis, an orthopedist and second opinion referral found that appellant had no pathology to her right knee other than some scarring. He opined that the arthroscopic surgery was unrelated to her accepted injury and that appellant appeared to have secondary gains to her complaints of pain. Dr. Curtis wrote that he "felt very strongly that appellant should have a psychiatric examination." He further indicated that she had no medical restrictions other than being deconditioned due to seven years of a sedentary existence.

In a July 11, 2000 report, Dr. Pelli wrote that appellant presented with multiple complaints including pain in both knees and hips, especially the right knee, back pain, twitches in her face and trouble sleeping. He diagnosed somatic dysfunction of the cervical lumbar and thoracic spine, myofascial pain syndrome consistent with fibromyalgia syndrome, obesity, possible manic disorder with possible obsessive-compulsive component and symptoms of carpal tunnel syndrome bilaterally.

In an October 10, 2000 decision, the Office rescinded its acceptance of appellant's knee condition and surgery and again proposed terminating her compensation for her back-related condition.

Appellant requested reconsideration. In support of her request, she submitted an October 13, 2000 functional capacity evaluation form report from Dr. Pelli that showed her continuing medical restrictions. In an accompanying narrative, Dr. Pelli wrote that appellant presented with multiple complaints including pain over the right inguinal and buttocks area, left leg pain and tenderness in her back. Dr. Pelli's diagnosis included somatic dysfunction of the cervical lumbar and thoracic spine, degenerative arthritis of the lumbar spine, degenerative thoracolumbar disc disease, fibromyalgia syndrome, obesity and depression.

In a December 15, 2000 decision, the Office terminated appellant's compensation finding that the facts of her knee injury, as presented by appellant, are contradictory and do not substantiate that her knee injury is related to the accepted incident.

[1] Appellant and her representative made requests to see Dr. Anson's reports due to a reference by the claims examiner to the probative value of a report by Dr. Anson and a subsequent referral to another second opinion examiner. The Office maintains that he never submitted a report, hence the need for another referral. This was explained to appellant and her representative. The record does not contain a report or a bill from Dr. Anson.

Appellant requested reconsideration and submitted a July 3, 2001 report from Dr. Pelli, who wrote:

> "[Appellant] has been in this office on multiple occasions since her first visit in June 1995…. Her initial history was [that] she was descending snow covered steps while working and slipped, catching herself and prevented a fall. [Appellant] proceeded on and slipped again this time falling on her buttocks and sliding forward with her legs sliding under a parked vehicle. Since that time she has complained of pain in the right knee and lower lumbosacral spine and right inguinal area. [Appellant] noted a pulling sensation over the left chest, pain into the medial and radial aspect of the left upper arm. She also noted a 'crunching' sensation in her neck as well.
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> "During [appellant's] subsequent many visits since 1995, she continued to complain of pain over the para-axial muscles and soft tissues, gluteal areas and medial aspect of both knees. She also noted discomfort in her left wrist, both hands and numbness in the right thumb and index finger, numbness in her legs with prolonged standing and pain in her neck and back especially in the paraspinous muscles and sift tissues…. As of [appellant's] last visit on July 3[,] 2001 she was also complaining of pain over the area around the left anterior superior iliac spine with pain radiating in the anterior aspect of the left thigh. This was consistent with meralgia paresthetica -- a condition involving pressure on the lateral femoral cutaneous nerve in her left inguinal area. This pressure is current secondary to her obesity, which is a problem related to her inability to be more active and to her depression…."
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> "My care of [appellant] has been since 1995. Since that time it has been my opinion that the original fall was the instigating event that brought on the complaints of her pain in the lumbar area and right knee. The pain now involving the myofascial tissues with the diagnosis of fibromyalgia syndrome has developed since the injury. This condition can be brought on by trauma. [Appellant's] depression and anxiety symptoms can be part of fibromyalgia syndrome as well. When more significantly depressed or anxious her symptoms are magnified.
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> "I believe that [appellant's] primary symptoms are now due to fibromyalgia, which created the ongoing pain syndrome since her original fall and the snow covered steps. As far as work[-]related physical activity, I (believe) that sitting, standing, walking, lifting or carrying anything will be uncomfortable for her … she has had numerous occasions where she has had problems with memory and sustained concentration. This is most likely a function of [appellant's] depression and fibromyalgia syndrome. She would have a great deal of trouble in a workplace.
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> "I believe [appellant] is disabled due to her chronic pain syndrome that has reached maximum medical improvement.... I feel that her depression magnifies

her chronic pain. I feel that these symptoms are related to the fall that originally precipitated her symptoms."

In a February 14, 2002 decision, the Office denied modification, finding that Dr. Pelli's report failed to explain how appellant's medical condition was related to her accepted incident in 1993.

In a June 5, 2002 letter, appellant requested reconsideration, arguing that her fibromyalgia with chronic pain, depression, sleep disturbance and obesity are consequential injuries causally related to the 1993 accepted back strain. In support of her request, appellant submitted reports from Dr. Pelli dated February 20 and January 9, 2002 and December 18, 2001. In the February 20, 2002 report, Dr. Pelli wrote that fibromyalgia is not a diagnosis that has any "evidence" based on historical findings and physical assessment of appellant. The January 9, 2002 and December 18, 2001 reports contain diagnosis and treatment plans already part of the record.

In an August 1, 2002 report, the Office denied modification, finding the medical evidence insufficiently rationalized.

The Board finds that the Office's decision properly rescinded its acceptance of appellant's right knee condition and authorization for surgery. The Board has upheld the Office's authority to reopen a claim at any time on its own motion under section 8128(a) of the Federal Employees' Compensation Act and, where supported by the evidence, set aside or modify a prior decision and issue a new decision.[2] The Board has noted, however, that the power to annul an award is not an arbitrary one and that an award for compensation can only be set aside in the manner provided by the compensation statute.[3] It is well established that once the Office accepts a claim, it has the burden of justifying termination or modification of compensation.[4] This holds true where, as here, the Office later decides that it has erroneously accepted a claim for compensation. In establishing that its prior acceptance was erroneous, the Office is required to provide a clear explanation of its rationale for rescission.[5]

The Office clearly explained that its October 10, 2000 rescission was based on the fact that appellant presented inconsistent stories about her fall; did not share all incidents related to her knee to some doctors and the fact that Dr. Klein, a Board certified orthopedist, opined that the 1998 arthroscopic surgery was not related to the accepted incident. The Office noted that appellant did not relate sliding under a parked vehicle and injuring her knee in her Form CA-1 or to the emergency room physician, Dr. Cochran or to Drs. Harrigan and Pierre-Engels and that she first mentioned the condition after she slipped while getting out of her husband's truck on April 2, 1997.

[2] *Eli Jacobs*, 32 ECAB 1147, 1151 (1981).

[3] *Doris J. Wright*, 49 ECAB 230 (1997); *Shelby J. Rycroft*, 44 ECAB 795 (1993).

[4] *See* 20 C.F.R. § 10.610.

[5] *Alice Roberts*, 42 ECAB 747 (1991).

The Board further finds that the Office properly terminated appellant's compensation.

Under the Act,[6] once the Office has accepted a claim it has the burden of justifying termination or modification of compensation benefits.[7] The Office may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.[8] The Office's burden of proof includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[9]

In support of its termination, the Office relied on the reports of Dr. Klein and Dr. Curtis. In his July 14, 1999 report, Dr. Klein, a Board-certified neurologist, found that appellant had a completely normal neurological examination. In support of his opinion, he cited results of a myelogram, CT scan and his own physical examination that showed no evidence of radiculopathy or any other medical conditions. Dr. Klein pointed out that appellant's subjective complaints of right leg pain are inconsistent with her left-sided lateral disc bulge at L3-4.

In his May 31, 2000 report, Dr. Curtis, a Board-certified orthopedist, wrote that he could find no existing pathology related to appellant's knee or back. He found the deep tendon reflexes of the knees and ankles to be symmetric and brisk, good muscle tone in both lower extremities and calves and no significant atrophy in her right leg. Dr. Curtis similarly found no objective evidence of any impairment of appellant's right knee.

In her request for reconsideration, appellant argued her conditions of fibromyalgia, sleep disorder and depression were consequential injuries to her accepted conditions. In support, she submitted several reports from Dr. Pelli, an osteopath, who specializes in family medicine, who attributed these conditions to her 1993 back and knee strains. But he did not explain how the back and knee strains in 1993 would evolve into fibromyalgia seven years later. Moreover, Dr. Pelli wrote that fibromyalgia is not a diagnosis that has any "evidence" based on historical findings and physical assessment of appellant. At best, his diagnosis and attribution of the condition to the accepted employment factors is speculative.

[6] 5 U.S.C. §§ 8101-8193.

[7] *Charles E. Minniss,* 40 ECAB 708, 716 (1989); *Vivien L. Minor,* 37 ECAB 541, 546 (1986).

[8] *Id.*

[9] *See Del K. Rykert,* 40 ECAB 284, 295-96 (1988).

For these reasons, the Board finds that the decisions of the Office of Workers' Compensation Programs dated August 2 and February 14, 2002 and December 15 and October 10, 2000 are affirmed.

Dated, Washington, DC
September 2, 2003

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member