United States Department of Labor
Employees' Compensation Appeals Board

M.W., Appellant	)	
and	)	**Docket No. 14-457**
	)	**Issued: August 12, 2014**
DEPARTMENT OF THE NAVY, PUGET SOUND NAVAL SHIPYARD, Bremerton, WA, Employer	)	

Appearances:
Appellant, pro se,
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Alternate Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On December 23, 2013 appellant filed a timely appeal from the November 25, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP), which denied his claim. Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant met his burden of proof to establish that his claim should be accepted for a consequential hip or back condition.

FACTUAL HISTORY

On June 24, 2004 appellant, then a 52-year-old engineering technician, sustained an injury when he fell about nine feet from a military van while removing a loose window screen

[1] 5 U.S.C. § 8101 *et seq.*

from a conex box. He stopped work on June 24, 2004. OWCP accepted the claim for left ankle calcaneus fracture. It authorized surgery on July 6, 2004 for a comminuted left calcaneus fracture. On August 17, 2005 surgery was performed to remove hardware from the left ankle. On December 6, 2006 additional surgery was conducted for left Achilles tendon lengthening and on January 13, 2009 for a left calcaneal osteotomy and hardware removal.

In a January 25, 2013 telephone call memorandum, appellant requested approval to see a chiropractor for his back and hip. OWCP noted that the claim was accepted for the left foot and ankle. In a January 25, 2013 letter, it informed appellant that, if he believed that his hip and back conditions were due to his accepted injury, he would need to submit medical evidence from a physician explaining the causal relationship.

In a February 7, 2013 report, Dr. Marc Suffis, Board-certified in emergency medicine and a treating physician, noted that appellant sustained an intra-articular complicated fracture of the left calcaneus with secondary post-traumatic osteoarthritis and chronic regional pain syndrome. Appellant had 29 percent left lower extremity impairment. Dr. Suffis indicated that appellant was "now stating that his back has been bothering him and he wanted to see a chiropractor and would like to get this covered under OWCP." He noted that appellant complained of tenderness in the right thoracolumbar spine. Dr. Suffis examined appellant and found that deep tendon reflexes were normal except for his left ankle. His review of the medical records revealed "no mention of back problems." Dr. Suffis opined that "someone who has been having a limp for nearly a decade and has use of a cane can develop myofascial back pain, I think intuitively that would be the case. It is curious that there is no mention of complaints before, although his wife stated [that] he has stated to his attending orthopedist that he has had back problems. I would therefore opine, on a more probable than not basis, that his thoracolumbar myofascial pain is secondary to antalgia and gait assistance from his calcaneal fracture." He referred appellant for chiropractic treatment.

On April 11, 2013 OWCP granted appellant a schedule award for 29 percent permanent impairment to the left lower extremity.

In a letter dated April 25, 2013, OWCP advised appellant that the February 7, 2013 report from Dr. Suffis noted that he had pain but that pain was not a firm medical diagnosis. It requested that appellant submit additional medical evidence to explain how his back and hip conditions were connected to his June 24, 2004 work injury.

Appellant provided a February 11, 2013 report from Dr. Eric W. Miller, a chiropractor, who noted that appellant related that, since his foot surgery, he had constant hip/pelvis pain, low back pain and mid back pain with tight muscles. Dr. Miller opined that appellant's body was continually compensating for his foot injury as it did not always move in a fluid motion, causing pressure on appellant's right pelvis and rotation to the right side, which caused his lumbar and thoracic spine vertebrae to be rotated to the left side and causing bilateral muscle imbalance. He advised that this would be an ongoing issue for appellant because of his foot injury. Dr. Miller noted subjective complaints of neck pain and muscle spasm, mid back pain and muscle spasm, low back pain and muscle spasm, bilateral anterior hip pain, right sacroiliac joint pain and left foot pain. He noted that the x-ray findings revealed multiple vertebral subluxations. Dr. Miller diagnosed soft tissue injuries in the neck, upper, mid and lower back resulting in multiple

vertebral subluxation complexes (misalignment/spinal dysfunctions and sprain/strains) in the thoracic, lumbar and sacrum due to the incident of June 24, 2004. He continued to treat appellant and provide manipulation of the spine.

In an April 30, 2013 report, Dr. Suffis noted that appellant developed low back and hip pain that was "a result of his prolonged, nine years, abnormal gait and ankle and foot position. The pain goes from the lower back to the hip region." He stated that lumbosacral x-rays were unremarkable with the exception of mild degenerative disc disease at the L5-Sl level. Dr. Suffis diagnosed lumbar and hip strain secondary to antalgia. He indicated that "[o]n a more probable than not basis, the cause of the strain on [appellant's] lower back and hip is secondary to his prolonged, markedly abnormal gait and I recommend this be included in his claim." An accompanying April 30, 2013 lumbar spine x-ray report, read by Dr. Steven A. Bell, a Board-certified diagnostic radiologist, was negative. Dr. Bell noted normal vertebral alignment and no significant disc space narrowing.

In a May 9, 2013 report, Dr. Suffis noted that appellant suffered a severe comminuted fracture of his left calcaneus in 2004 with resultant subtalar fusion and developed chronic regional pain syndrome. As a result, appellant had a persistent antalgic gait that required him to have his left foot in an everted position. Dr. Suffis indicated that further surgery has been suggested to include joint replacement or total ankle fusion. He opined that:

> "I do not think it is much of a stretch of the imagination to determine that as … severe fracture and long[-]standing antalgic gait, now nearly nine years with the … position, he has developed hip and back pain. It is clear that the lower back pain and hip pain occurred as a result of his markedly abnormal gait from his primary injury. I therefore request that this be included as part of [appellant's] claim."

Dr. Suffis further explained that the lumbar spine x-rays were unremarkable, which indicated that appellant had a myofascial condition, which made sense as the source of pain was from a chronic limp.

In a report dated August 12, 2013, Dr. Kenneth D. Sawyer, an OWCP medical adviser, noted appellant's history of injury and treatment. He did not recommend that OWCP accept any lumbar and/or hip strain or any spinal subluxations as part of the current claim. The medical adviser indicated that the argument for doing so was weak and the preponderance of evidence did not support causal relation. He noted that there was no record of any original trauma, symptoms or evidence of injury to the back or hips from the 2004 injury and there were no symptoms related to the back or hips until some eight years following the injury. Dr. Sawyer stated that there was no evidence of any significant leg length inequality and the lumbar examination performed by Dr. Suffis was normal. The radiology findings in the lumbar spine were normal, including flexion-extension lateral views. Dr. Sawyer explained that while "it was possible for an antalgic gait to place asymmetrical stress on the lumbar spine, the use of a cane does not necessarily do so." He noted that possible was not the same as probable. The medical adviser also stated that it was "estimated that 80 percent of the adult population develops disabling back pain at some time in their life, in the absence of any specific injury or gait abnormality. Because of this, it is not appropriate to state that this man's back pain is due to a

gait abnormality, on a more probable than not basis, simply because there is no other specific thing to blame it on."

In a November 25, 2013 decision, OWCP denied appellant's request to accept his claim for a lumbar or hip strain or thoracic, lumbar and sacrum subluxations. It found that the medical evidence was insufficient to establish causal relation to the accepted injury of 2004.

LEGAL PRECEDENT

To establish a causal relationship between the condition as well as any attendant disability claimed and the employment injury, an employee must submit rationalized medical evidence based on a complete medical and factual background, supporting such a causal relationship.[2] Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[3] Rationalized medical evidence is evidence which includes a physician's rationalized medical opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty and must be supported by medial rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[4] Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[5]

FECA provides compensation for the disability of an employee resulting from personal injury sustained while in the performance of his or her duty.[6] 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 attributable to the employee's own intentional conduct.[7]

Section 8123(a), in pertinent part, provides that if there is a 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.[8]

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[2] *Phillip L. Barnes*, 55 ECAB 426 (2004).

[3] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[4] *Leslie C. Moore*, 52 ECAB 132 (2000).

[5] *Ernest St. Pierre*, 51 ECAB 623 (2000).

[6] 5 U.S.C. § 8102(a).

[7] *Albert F. Ranieri*, 55 ECAB 598 (2004).

[8] 5 U.S.C. § 8123(a).

ANALYSIS

The Board finds that this case is not in posture for decision due to an unresolved conflict in the medical evidence.

Appellant's treating physician, Dr. Suffis, explained in an April 30, 2013 report that appellant developed low back and hip pain. He opined that it was "a result of his prolonged, nine years, abnormal gait and ankle and foot position" and indicated that the pain went from the lower back to the hip region. Dr. Suffis found that the lumbosacral x-rays were unremarkable with the exception of mild degenerative disc disease at L5-Sl. He diagnosed lumbar and hip strain secondary to antalgia. Dr. Suffis opined that "[o]n a more probable than not basis, the cause of the strain on [appellant's] lower back and hip is secondary to his prolonged, markedly abnormal gait and I recommend this be included in his claim." On May 9, 2013 he explained that appellant suffered a severe comminuted fracture of his left calcaneus in 2004 with resultant subtalar fusion and developed chronic regional pain syndrome. As a result, appellant had a persistent antalgic gait that required him to have his left foot in an everted position. Dr. Suffis opined that, due to the severe fracture and longstanding antalgic gait, for nearly nine years, appellant developed hip and back pain. He explained that the lower back pain and hip pain occurred as a result of appellant's markedly abnormal gait from his primary injury. Dr. Suffis added that, while the lumbar spine x-rays were unremarkable, this indicated that appellant had a myofascial condition, which made sense as the source of pain was from a chronic limp.

On August 12, 2013 Dr. Sawyer opined that appellant's lumbar or hip strain, as well as any spinal subluxation, was not causally related to the accepted injury in 2004. He explained that there was no record of any original trauma, symptoms or evidence of injury to the back or hips at the time of the original injury nor any symptoms in the back or hips found in the medical records until some eight years following the injury. The medical adviser also noted that there was no evidence of any significant leg length inequality and that Dr. Suffis' lumbar examination was normal. He explained that, while "it was possible for an antalgic gait to place asymmetrical stress on the lumbar spine, the use of a cane does not necessarily do so." The medical adviser argued that possible was not the same as probable and indicated that "80 percent of the adult population develops disabling back pain at some time in their life, in the absence of any specific injury or gait abnormality. Because of this, it is not appropriate to state that this man's back pain is due to a gait abnormality, on a more probable than not basis, simply because there is no other specific thing to blame it on."

As a conflict in opinion exists between Dr. Suffis and Dr. Sawyer, the case will be remanded to refer appellant to an impartial medical examiner to resolve the medical conflict. If a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination and it will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[9] The Board will set aside OWCP's November 25, 2013 decision and remand the case to OWCP for further medical development. Following this and any such further development as

[9] 20 C.F.R. § 10.321(b). *See also R.H.*, 59 ECAB 382 (2008).

may be deemed necessary, OWCP shall issue a final decision on whether appellant's hip or back condition arose as a consequence of his accepted June 24, 2004 employment injuries.

CONCLUSION

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

ORDER

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

Issued: August 12, 2014
Washington, DC

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

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

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