File Number:
HR10-D-H

U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 50
LONDON, KY 40742-8300
Phone: (202) 693-0045

MAY 12 2010

RECEIVED MAY 17 2010

Date of Injury:
Employee:

Dear Mr. :

This is in reference to your workers' compensation claim. Pursuant to your request for a hearing, the case file was transferred to the Branch of Hearings and Review.

A hearing was held on 02/22/2010 As a result of such hearing, it has been determined that the decision issued by the District Office should be vacated and the case remanded to the district office for further action as explained in the enclosed copy of the Hearing Representative's Decision.

Your case file has been returned to the Jacksonville District Office. You may contact that office by writing to our Central Mail Room at the following address:

US DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 6 JAC
LONDON, KY 40742-8300

Sincerely,

Debra Harvey
Hearing Representative

DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION
ATLANTA VETERANS MEDICAL CENTER
1670 CLAIRMONT ROAD
DECATUR, GA 30033

PAUL H FELSER
ATTORNEY AT LAW
POST OFFICE BOX 10267
SAVANNAH, GA 31412

U.S. DEPARTMENT OF LABOR
Office of Workers' Compensation Programs

DECISION OF THE HEARING REPRESENTATIVE

In the matter of the claim for compensation under Title 5, U.S. Code 8101 et seq. of , Claimant, Employed by the Department of Veterans Affairs, Atlanta, Georgia. Case No. Oral hearing was held in Jacksonville, Florida, on February 22, 2010.

The issue is whether the claimant sustained a consequential injury on February 22, 2009.

The claimant, date of birth, , is employed by the Department of Veterans Affairs in Atlanta, Georgia, as an Electrician. He was initially injured on October 19, 2006, with his claim being accepted for a lumbar strain, as well as left knee strain, tear, and derangement. He underwent a left knee anterior cruciate ligament reconstruction on June 5, 2007.

A lumbar MRI of November 19, 2006, showed bilateral pars defects at the L5 level with no edema. He had a small protruding disc at the L4-5 level with no herniations noted. He was seen on December 23, 2007, at Gwinnett Hospital for right foot numbness and weakness when "he tried to walk and he noticed that his foot was striking the ground." The exam was consistent with peroneal nerve peripheral neuropathy.

On January 11, 2008, Dr. Scott Gillogly stated the claimant had been cleared to return to work for the knee, but, "unfortunately, he has now developed what appears to be a lumbosacral spine herniated pulposus with resultant foot drop and decreased sensation involving the right lower extremity. This has not been established as a worker's compensation injury to date though there is remaining question as to whether this will be the case."

Dr. David Krendel, neurologist, stated on January 17, 2008, that the claimant stood up after being seated for a while and noticed right foot drop. He diagnosed a probable peroneal compression neuropathy and ordered Electrodiagnostic studies. The studies showed a peroneal compression neuropathy.

On May 23, 2008, Dr. Veronica Patterson stated the claimant continued to have foot drop from a peroneal injury of his right lower extremity. "It is noted, that he does have a herniated lumbar disc that has caused this foot drop. The herniated lumbar disc has developed secondary to his fall/injury on the job."

Dr. Nabil Muhanna examined the claimant on December 11, 2008. He noted the employment injury of October 2006 and stated the claimant continued to have numbness in the right foot, along with low back pain and radiation down the lateral aspect of the

right leg. The claimant walked with a limp and "flopped" his right foot and swung his right leg when he walked. There was an absent right ankle jerk. There was no weakness in the foot and strength was equal. There was a positive straight leg raising on the right at 90 degrees. Dr. Muhanna stated the claimant had "slippage" at L5-S1, along with a bilateral pars defect at L5-S1. He recommended another MRI scan and a nerve conduction study of the bilateral lower extremities.

The MRI was performed on February 27, 2009, and showed a Grade 1 spondylolisthesis of L5 on S1. Bilateral pars fractures were suspected, not associated with central stenosis. He also had an L4-5 posterior disc protrusion. EMG and nerve conduction studies of both lower extremities, performed on March 3, 2009, were normal.

On March 3, 2009, Dr. Muhanna stated the claimant had a pars defect at L5-S1 and severe foraminal stenosis at L5-S1 along with numbness and pain in the right leg. "The abnormalities in his lower back are probably responsible for most of his symptoms in his hip, leg, and foot. . . This situation has been going on since October 2006. It has not gotten better since October 2006; it has gotten worse."

Dr. John G. Heller, orthopedist, stated in a July 7, 2009, consultative report, that "his continuing right L5 root symptoms may well be due to his L5-S1 grade 1 isthmic spondylolisthesis. I further believe that the L4-5 annular tear, disk degeneration, and disk protrusion may be etiologic in this situation. That pathology would also affect the right L5 nerve root, as well as contributes to back pain." He stated he believed a more detailed evaluation was needed to determine if a problem at the L4-5 level was part of the problem. He stated he had concerns with "the notion of this being a 'peroneal neuropathy.'"

In a follow-up report of August 25, 2009, Dr. Heller stated the claimant had spina bifida at the L5 level and "probably isthmic spondylolisthesis, L5-S1." He stated, "the nature of the congenital defect in his L5 posterior origin, how this predisposes him to potential problems later in life. It seems as though his injuries precipitated a mixed picture of back pain and right lower extremity pain that is refractory to medical management. There is also a disk degeneration and annular tear at L4-5. Either pathologic entity could affect his L5 nerve root. Thus it is entirely possible that he is experiencing symptoms from a combination of problems." He recommended lumbar discography and post-diskogram CT scan prior to any consideration of surgery. The Office did not accept any additional condition as work-related.

The claimant sustained another knee injury on July 30, 2007, that was accepted and administratively closed.

The present claim was filed on June 4, 2009. The claimant stated he sustained a left femur fracture with bone cartilage damage secondary to right foot drop while walking on February 22, 2009. He stated the foot drop caused him to fall on the left knee and on his head. He stated this was consequential to his prior injuries.

The Employing Agency challenged the claim, stating, "The injury occurred off the employing agency's premises and the employee was not involved in official off premise duties Injury was not work related Employee fell at home not work related, can not verify what the employee was actually doing at the time of injury Per Employees statement and age the injury is more server [sic] then the mode." The agency also questioned why the claimant waited three months before filing the claim

The District Office requested medical evidence from the claimant on June 10, 2008, to establish the claim Records from the prior claim were received New medical evidence was also received.

Notes from the Employee Health Clinic dated February 24, 2009, were also received. These notes from a nurse practitioner stated the claimant reported he fell at home the prior weekend and injured his right foot secondary to "foot drop." This note reported that the claimant hit his knee and face.

A February 23, 2009, report from Dr Patterson stated he was seen for a one-day history of pain and swelling in the left knee from a fall due to foot drop He was diagnosed with internal derangement of the knee and a knee contusion.

Dr Patterson provided a June 24, 2009, report stating the claimant was originally seen for injuries after his October 23, 2006, fall He presented with left knee pain, swelling and instability of the left knee and back pain that radiated into his right buttock, thigh and leg with numbness She noted he had left knee surgery She stated, "He continues to have pain in the back with numbness into his right lower extremity and with time has developed a right foot drop or peroneal injury The peroneal injury most likely occurred due to prolongation of a nerve injury from a herniated disc." She diagnosed internal derangement of the knee, herniated lumbar disc disease with myelopathy and a peroneal nerve injury She stated, "It is my belief that these injuries are as a result of patient's fall in 2006."

The claimant also submitted a written statement in which he stated he had experienced continuing symptoms from the original injury in 2006 He stated he had fallen numerous times at home and at work He stated he fell at home on December 23, 2007, after his right foot "ceased to function" He also suffered an osteochondral impact fracture after a March 22, 2009, fall at home He stated surgery has been recommended both for the fracture, as well as a spinal fusion.

The claim was denied on July 20, 2009, with the Office finding the evidence did not establish an injury in the performance of duty since the claimant fell at home The claimant disagreed with this decision and through his attorney, Paul Felser, requested an oral hearing before an OWCP Hearing Representative.

The hearing was held on February 22, 2010, in Jacksonville, Florida The clamant was not present but was represented by Mr Felser The attorney acknowledged the prior claims and stated that it was his contention that the injuries the claimant sustained led to

the foot drop that was responsible for the subsequent falls. "And, as you've indicated, if the fall occurred as a result of the foot drop, even a fall off premises could be considered consequential to other work related injuries, and that's what has been the case in this instance. We feel that the original injuries led directly to the foot drop and ultimately resulted in the falls that he's experienced."[1] He discussed the medical evidence and stated he would be submitted additional evidence for consideration in the final decision

The record was left open for receipt of additional evidence. A copy of the hearing transcript was sent to the Employing Agency for review and comment on March 10, 2010. The agency did not provide any comments for review.

Mr. Felser submitted his post-hearing brief summarizing his comments. He also submitted additional medical evidence from Dr. Gillogly, dated January 29, 2010. Dr. Gillogly stated the claimant was known to have a prior left knee ACL tear and a medial meniscus tear after which he underwent surgery. He suffered re-injury in June 2007 resulting in an osteochondral impaction injury. He was also known to have lumbosacral spine degenerative disc disease and right lower extremity foot drop. "As a result of this foot drop, he had taken a fall and sustained a re-injury to his left knee MRI documenting abnormal edema involving the anterior aspect of the medial femoral condyle compatible with an osteochondral impaction injury. Based upon his mechanism of injury in both the original injury and subsequent re-injury (fall), it is our opinion that the aforementioned diagnoses are work-related."

Dr. Muhanna also submitted a report dated March 4, 2010. The physician stated the claimant had slippage of L5-S1 related to pars defect bilaterally L5-S1. He stated:

> "We are going to explain this on the basis of injury as of our history, which was described to us on this visit 12/11/2008, which said the patient was loading a pallet onto a trailer that was backed on an incline when the pallet jack fell through the floor of the trailer causing him to twist his leg and back and he was thrown onto the left side of his body. This condition has been caused and aggravated by this accident. The pars defect could have been present previously, but the significant trauma that happened to this patient could have either caused or aggravated additional condition, which is related to the first condition. This patient will require surgery for the level of L5-S1 fusion. That is necessary because this condition could cause slippage of two bone of the back on each other, which entrap and squeeze or compress the nerves in the back and that causes back pain and leg pain. It could also cause back pain because of the mechanics of the weakness of the back."

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 likewise arises out of the employment, unless it is the result of an independent intervening cause attributable to a claimant's own intentional conduct. The basic rule is that a subsequent injury, whether an

[1] Hearing transcript, pages 6-7

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 [2]

In this case, the claimant stated he fell and sustained a fracture due to foot drop that he related to the 2006 injury. Even though the claimant was off-premises when this injury occurred, it could be considered consequential if it is determined to be a natural result of the 2006 injury. I find that the medical reports in the prior claim establish a *prima facie* case for additional employment-related back and foot conditions. There is, however, no rationalized medical evidence that is sufficient to warrant acceptance of additional conditions at this time. A prima facie claim is one that on first appearance demonstrates entitlement to compensation and which always requires further development if it is not accepted.[3]

Therefore, the Office's decision dated July 20, 2009, is hereby SET ASIDE and the claim REMANDED for additional development. The three claims should be combined, pursuant to the Office's procedures. A Statement of Accepted Facts outlining all injuries should be prepared and the claimant should be referred to an appropriate Board-certified specialist for a second opinion examination. The physician should perform an examination and provide objective findings and firm diagnoses of all conditions. Any diagnostic testing deemed necessary should be authorized. The physician should provide a well-rationalized medical report that, first, establishes whether any additional back or foot-related condition(s) should be accepted in the prior claim. If the evidence establishes additional conditions are employment related, the specialist should then determine if the fracture claimed in the instant claim was a result of any of these conditions.

Once the medical report has been received, and after completion of any additional development the Office deems necessary, *de novo* decisions should be issued.

DATED: MAY 12 2010

WASHINGTON, D.C.

DEBRA W. HARVEY
Hearing Representative
For
Director, Office of Workers'
Compensation Programs

[2] *Dennis J. Lasanen*, 41 ECAB ___ (Docket No. 90-1961, issued August 15, 1990).
[3] *Robert P. Bourgeois*, 45 ECAB ___ (Docket No. 93-1155, issued July 1, 1994).