United States Department of Labor
Employees' Compensation Appeals Board

ROGER D. HUTTO, Appellant	)	
and	)	**Docket No. 05-166**
	)	**Issued: April 13, 2005**
DEPARTMENT OF THE NAVY, CHARLESTON NAVAL SHIPYARD, Charleston, SC, Employer	)	

Appearances:
Roger D. Hutto, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chairman
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member

JURISDICTION

On October 20, 2004 appellant filed a timely appeal from the September 16, 2004 merit decision of the Office of Workers' Compensation Programs, which denied his claim for an additional schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to review the Office's decision.

ISSUE

The issue is whether appellant's herniated disc at L4-5 and any resulting permanent impairment, is causally related to his August 17, 1998 employment injury.

FACTUAL HISTORY

On September 25, 1980 appellant, then a 30-year-old rigger, sustained an injury in the performance of duty. He stooped down in a deep knee bend position to lash equipment to a pallet and when he stood up he felt a sharp pain in his left knee. The Office accepted appellant's

claim for left knee strain, aggravation of chondromalacia and synovial herniation.[1] On November 22, 1983 he received a schedule award for a 10 percent impairment of the left lower extremity.

On August 17, 1998 appellant sustained another injury in the performance of duty. He was pulling a line cart at the dry dock when he stepped in a hole and twisted his left knee. The Office accepted his claim for left knee strain. On June 3, 1999 appellant filed a claim for a schedule award.

In a decision dated December 21, 1999, the Office denied an additional schedule award for appellant's left lower extremity. The Office explained that he had already received a schedule award for a 10 percent impairment, so current medical evidence that he had a 7 percent permanent impairment of that extremity did not entitle him to an additional award.

Appellant requested an oral hearing before an Office hearing representative. To support his claim for an additional schedule award, he submitted the August 3, 2000 report of Dr. John A. Muenz, Jr., a specialist in physical medicine and rehabilitation. Appellant reported that on August 17, 1998 while functioning in his usual duties at work, he had a trip-and-fall injury. Dr. Muenz noted that appellant had progressive problems with pain, weakness and wasting away in his left lower extremity since that injury. He reported that a magnetic resonance imaging (MRI) scan of the lumbar spine obtained on November 23, 1999 showed bilateral neuroforaminal narrowing at the L5-S1 level, believed due to facet degeneration. He diagnosed left lower limb radiculopathy; muscle wasting and atrophy, left lower limb; degenerative joint disease, left knee; and decreased functional abilities secondary to the above. Dr. Muenz then addressed the issue of causal relationship:

> "I believe that [appellant's] problems are directly and causally related to his work injury of August 17, 1998. I believe that at the time of his accident, he twisted his left knee with force sufficient to reinjure and aggravate a preexisting left knee problem. I also believe that at the time of the accident, [appellant] twisted with such force so as to cause damage to his lumbar spine, resulting in radiculopathy in the left lower limb (nerve damage at the spine causing problems in his left leg). He has, therefore, sustained two separate, but related, injuries in relation to his August 17, 1998 accident, an aggravation of a preexisting knee problem and a new lumbar radiculopathy. These findings are substantiated by his history, his clinical examinations and his diagnostic testing, including his electrodiagnostic testing suggestive of radiculopathy."

Subtracting appellant's previous rating of 10 percent, which he considered justified, Dr. Muenz concluded that he had a new lower extremity impairment of 23 percent.

On March 13, 2001 an Office medical consultant reported that, when appellant was examined three days following his August 17, 1998 employment injury, the medical report noted no back complaints or findings related to back pathology. The consultant also reported that records following the 1998 injury provided the same diagnosis and physical findings (muscle

[1] Claim No. 06-0258474.

atrophy and leg weakness) as the 1980 injury. There was no objective evidence, he stated that the 1998 injury included a lumbar radiculopathy or that appellant's left leg pathology was directly associated with lumbar root involvement.

On April 13, 2001 an Office hearing representative affirmed the denial of an additional schedule award.

The record indicates that appellant sustained a low back injury in the performance of duty on May 31, 2001 which the Office accepted for lumbar strain.[2]

Appellant requested reconsideration of the hearing representative's April 13, 2001 decision. He argued that electrodiagnostic studies confirmed that nerve damage attributable to the 1998 injury was responsible for his resulting leg weakness and muscle atrophy. In support of his request for reconsideration, appellant submitted, among other things, an April 8, 2002 report from Dr. Muenz, who reported that an MRI scan following the 2001 injury revealed an L4-5 herniated disc with left lateral foramina stenosis. Electrodiagnostic testing performed at the same time revealed a left L4-5-S1 radiculopathy of longstanding etiology.[3] As these were chronic conditions, Dr. Muenz reasoned, the May 31, 2001 injury was an aggravation of a previous underlying lumbar radiculopathy, a condition that appellant sustained in 1998:

> "With this MRI [scan] evidence and with the electrodiagnostic testing evidence, it can now be stated, most probably, within a reasonable degree of probability, that [appellant's] left lower extremity thigh atrophy is as a direct result of a herniated lumbar disc, which is causing pressure on the L4-L5-S1 nerves on the left, causing weakness of the left thigh and calf, causing his left lower extremity weakness. This left lower extremity weakness has had and continues to have, since 1998, significant impact on his general functional abilities, including his abilities to perform his work.… It is now known, as referenced above, that [appellant] has left lower extremity atrophy as a direct 'neurogenic' etiology, a herniated left lumbar disc."

Dr. Muenz explained that there was a distinct difference between the 1980 and 1998 injuries, as the 1980 injury involved only the left knee, while the 1998 injury involved the left knee and lumbar spine: "The 1998 injury caused left lower extremity problems due to knee trauma and lumbar radiculopathy." He revised his evaluation of appellant's impairment by reporting a 56 percent impairment of the left lower extremity.

Appellant also submitted reports from Dr. Mark A. Gold, a consulting neurosurgeon. On August 20, 2001 he gave a clinical impression of left-sided leg pain and progressive weakness due to L4-5 disc protrusion with L4 and L5 radiculopathy: "This … dis[c] protrusion would

[2] Claim No. 06-2035825. Whether this injury caused any permanent impairment to appellant's left lower extremity is not before the Board on this appeal.

[3] The MRI scan obtained on January 25, 2002 revealed: "L4-5 mild central broad-based disc herniation [protrusion] which results in borderline central canal and mild bilateral neural foraminal stenosis, slightly greater on the left, unchanged in comparison to June 29, 2001 [prior examination]."

seem more likely than not to be due to the injury described occurring in 1998, with subsequent exacerbation again in 2001." On October 5, 2001 he reported the following:

> "We went over the lumbar myelogram/CT [computerized tomography] scan together. There is no obvious neural compression at any level. There is mild disc bulging at L4-5, but this does not cause stenosis either centrally or laterally. Since there is no neural compression, I did not recommend any sort of surgical procedure. I do wonder whether his EMG/NCV [electromyogram/nerve conduction velocity] changes may be due to the original injury and the subsequent loss of muscle mass may be related to the original injury. However, at this point and since there is no neural compression, his presumed nerve root injury would not be amenable to any sort of surgical amelioration. If [appellant's] muscle atrophy were to progress or if he were to develop muscle atrophy involving any other myotome, I would recommend referral to a neuromuscular specialist and he may then need to have a muscle biopsy. Since there is no neurosurgical amenable problem, I will release [appellant] from my care and follow him as needed."

In a decision dated June 20, 2003, the Office reviewed the merits of appellant's claim and denied modification of its prior decision. The Office found that the weight of the medical evidence established that appellant sustained no additional impairment to the left knee as a result of the August 17, 1998 injury and that no diagnosed lumbar condition, including lumbar radiculopathy, was causally related to the accepted injury.

Appellant requested reconsideration. He argued that further development of the medical evidence was warranted at the very least. Appellant also submitted, among other things, an October 22, 2003 neuromuscular consultation from Dr. Alan R. Berger, who reported that appellant never had an identifiable anatomic abnormality that could account for his root dysfunction. He noted that appellant had a mild annular bulge at L5, according to Dr. Gold, but no definite nerve compression or canal stenosis. Dr. Berger commented: "This remains an unsettling case. On clinical examination he continues to show what appears to be L5 predominant segmental dysfunction. Whether there is a component of S1 is uncertain although the ankle jerks are symmetric. I am not sure I have anything more to add."

In a decision dated September 16, 2004, the Office reviewed the merits of appellant's claim and denied modification of its prior decision.

LEGAL PRECEDENT

A claimant seeking benefits under the Federal Employees' Compensation Act[4] has the burden of proof to establish the essential elements of his claim by the weight of the evidence,[5] including that he sustained an injury in the performance of duty and that any specific condition

[4] 5 U.S.C. §§ 8101-8193.

[5] *Nathaniel Milton*, 37 ECAB 712 (1986); *Joseph M. Whelan*, 20 ECAB 55 (1968) and cases cited therein.

or disability for work for which he claims compensation is causally related to that employment injury.[6]

The evidence generally required to establish causal relationship is rationalized medical opinion evidence. The claimant must submit a rationalized medical opinion that supports a causal connection between his current condition and the employment injury. The medical opinion must be based on a complete factual and medical background with an accurate history of the claimant's employment injury and must explain from a medical perspective how the current condition is related to the injury.[7]

ANALYSIS

Appellant seeks an additional schedule award for his left lower extremity on the grounds that the August 17, 1998 incident at work, in which he stepped into a hole while pulling a line cart, not only caused him to twist his knee, but also caused an L4-5 herniated disc, radiculopathy which atrophied his left lower extremity. The Office accepted that he sustained a left knee strain while in the performance of duty. Appellant, therefore, bears the burden of proof to establish that the condition for which he seeks compensation, the L4-5 herniated disc and any resulting impairment, is causally related to the August 17, 1998 employment injury.

Appellant's claim finds support in the reports of his physiatrist, Dr. Muenz, who noted progressive problems with pain, weakness and wasting away in the left lower extremity since the August 17, 1998 employment injury. Standing alone, however, such a temporal relationship is not sufficient to establish a causal connection. The Board has held that, when a physician concludes that a condition is causally related to an employment because the employee was asymptomatic before the employment injury, the opinion is insufficient, without supporting medical rationale to establish causal relationship.[8] Thus, while a temporal relationship may be consistent with a causal one, the physician must offer sound medical reasoning to establish the causal link.

This is where the reports of Dr. Muenz are lacking. In his August 3, 2000 report, Dr. Muenz unequivocally expressed his belief that appellant sustained a new lumbar radiculopathy on August 17, 1998: "I believe that at the time of his accident, [appellant] twisted his left knee with force sufficient to reinjure and aggravate a preexisting left knee problem. I also believe that at the time of the accident, [he] twisted with such force so as to cause damage to his lumbar spine, resulting in radiculopathy in the left lower limb (nerve damage at the spine causing problems in his left leg)." Dr. Muenz did not explain the basis of this second belief. The Board has carefully reviewed the record and can find nothing in the factual or medical evidence reasonably contemporaneous to the August 17, 1998 incident to support that appellant twisted his back that day, forcefully or otherwise. All of his descriptions of the injury, all of his complaints and clinical findings and medical attention, were directed to the left knee. It was not until

[6] *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[7] *John A. Ceresoli, Sr.*, 40 ECAB 305 (1988).

[8] *Thomas D. Petrylak*, 39 ECAB 276 (1987).

October 20, 1999 that the neuromuscular consultant, Dr. Berger, obtained an electrodiagnostic study to investigate whether there was a lumbosacral radicular, plexus or sciatic nerve dysfunction causing appellant's lateral calf and foot sensory complaints.[9] Until then, the low back was simply not an issue.

Because Dr. Muenz based his opinion on a twisting injury of "such force" that it caused a herniated disc, he must either establish a sufficient foundation in the record for this mechanism of injury or provide a convincing medical explanation for how such a forceful injury occurred without apparent notice by appellant or his medical care providers. It is not necessary that the explanation be so conclusive as to suggest causal connection beyond all possible doubt; the evidence required is only that necessary to convince the adjudicator that the conclusion drawn is rational, sound and logical.[10] Dr. Muenz should also account for Dr. Berger's October 22, 2003 observation that appellant had a mild annular bulge at L5 but no definite nerve compression or canal stenosis. Dr. Berger reported that appellant never had an identifiable anatomic abnormality that could account for his root dysfunction. This observation tends to undermine the anatomic basis for Dr. Muenz's opinion on causal relationship.

The only other opinion supporting appellant's claim comes from Dr. Gold, the consulting neurosurgeon, on August 20, 2001: "This [L4-5] dis[c] protrusion would seem more likely than not to be due to the injury described occurring in 1998, with subsequent exacerbation again in 2001." Without a well-reasoned medical explanation to support this conclusion, Dr. Gold's opinion has little probative value.[11]

In the absence of medical reasoning sufficient to establish that appellant's L4-5 herniated disc, and any resulting permanent impairment, is causally related to his August 17, 1998 employment injury, the Board finds that appellant has not met his burden of proof.

CONCLUSION

Appellant has not met his burden of proof to establish that his herniated disc at L4-5 and any resulting permanent impairment, is causally related to his August 17, 1998 employment injury.

[9] Dr. Berger's clinical impression was that appellant had a sensory disturbance of the L5 dermatome, consistent with atrophy in the calf but not the thigh, the apparent wasting of which "may be due to disuse more than true neurogenic atrophy." He reported that findings obtained that day differed significantly from those of a study performed on August 4, 1999.

[10] *Kenneth J. Deerman*, 34 ECAB 641, 645 (1983).

[11] The Board has held that medical conclusions unsupported by rationale are of little probative value. *Ceferino L. Gonzales*, 32 ECAB 1591 (1981); *George Randolph Taylor*, 6 ECAB 968 (1954).

ORDER

IT IS HEREBY ORDERED THAT the September 16, 2004 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 13, 2005
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member