United States Department of Labor
Employees' Compensation Appeals Board

C.S., Appellant	)	
and	)	**Docket No. 06-1555**
	)	**Issued: March 26, 2007**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Leavenworth, KS, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On June 27, 2006 appellant filed a timely appeal from the Office of Workers' Compensation Programs' decisions dated August 8 and October 20, 2005 and April 18, 2006, which denied her claim of a lumbosacral condition. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits.

ISSUE

The issue is whether appellant met her burden of proof to establish that her claim should be expanded to include a consequential L5-S1 condition, and authorization for an L5 and L5-S1 percutaneous discectomy.

FACTUAL HISTORY

On January 8, 2002 appellant, then a 45-year-old supervisor in health information management, filed a traumatic injury claim alleging that on January 7, 2002 she slipped on icy

steps in the performance of duty.[1] The Office accepted the claim for a lumbar strain.[2] On September 10, 2002 the Office authorized lumbar microdisc surgery at L4-5.[3] It also accepted bilateral chondromalacia of the patella, right medial meniscus tear and left medial meniscus tear with surgical repair.

A magnetic resonance imaging (MRI) scan dated October 23, 2003, read by Dr. Kenneth Alfieri, a Board-certified diagnostic radiologist, revealed mild bulging posteriorly of the L4-5 disc with associated facet hypertrophy and significant bilateral neural foraminal narrowing.

In a January 8, 2004 report, Dr. Frank P. Holladay, a Board-certified neurosurgeon, diagnosed appellant with exacerbation of lumbar strain and opined that it was "perhaps" due to problems with her knees or because of degenerative disease in her lower back. In a February 9, 2004 report, he determined that appellant had foraminal narrowing at L4-5 on the right side but opined that "it did not appear to be severe." Dr. Holladay recommended a lumbar myelogram. In a February 23, 2004 lumbar myelogram, Dr. Thomas W. Zinn, a Board-certified diagnostic radiologist, opined that appellant had a bulging disc within the left lateral recess at L4-5; however, it did not displace the L5 root or produce significant spinal stenosis. He indicated that this finding was "invisible" on the myelogram and that no other abnormalities were noted. In a March 1, 2004 report, Dr. Holladay noted that appellant related low back pain radiating into the leg; however, lumbar myelogram results were normal. He diagnosed chronic lumbar strain and recommended treatment with a physiatrist. In a January 28, 2005 report, Dr. Holladay noted that he could not do anything further for appellant.

Dr. S.R. Reddy Katta, a Board-certified physiatrist, provided reports dating from March 2004 to March 2005. He advised that appellant started having lower back pain after a fall on the ice on January 7, 2002. Dr. Katta determined that appellant had chronic lower back pain as a result of her degenerative disc disease, and associated it with lumbar paraspinal and gluteal muscle strain and right trochanteric bursitis. He noted that appellant had degenerative joint disease of both knees with left anserine bursitis and no clinical evidence of ongoing lumbar radiculopathy.

In an August 23, 2004 report, Dr. Brian Jones, a Board-certified anesthesiologist, noted that appellant's MRI scan showed a recurrent protruding disc at L4-5. In an October 11, 2004 follow-up report, he recommended a caudal epidural steroid injection.

[1] Appellant has a separate claim under File No. 110167010 for an injury on June 9, 1998 that was accepted for left shoulder strain and impingement syndrome, aggravation of degenerative osteoarthritis, neck strain and lumbar back strain. It was determined that the neck and low back strains had resolved by July 10, 1998. The case was expanded to accept a left shoulder arthroscopy. The case was on appeal before the Board in Docket No. 04-1584 (issued June 7, 2004). The Board affirmed the Office's September 23, 2003 schedule award decision, finding that appellant had no more than a 10 percent impairment of her left arm.

[2] Appellant returned to regular duty on March 6, 2002.

[3] Appellant returned to regular duty on November 12, 2002. The record reflects that she has a nonwork-related left shoulder impingement with surgery which was performed on August 18, 1993 and a prolapsed mitral valve.

In a May 17, 2005 report, Dr. Mark A. Greenfield, a Board-certified anesthesiologist, noted that appellant was initially injured in January 2002. Appellant related that she was house cleaning the day before and was not able to move at all. Dr. Greenfield diagnosed intervertebral disc disorder, lumbar or lumbosacral intervertebral disc, and lumbar radiculopathy and advised that he would proceed with an electromyogram (EMG) and lumbar discography. In a June 21, 2005 discogram, he noted that appellant had low back pain without radiation at the L4-5 and L5-S1 levels, a posterior bulging disc with a degenerative pattern, bilateral hip pain, and posterior protrusion and diagnosed lumbar radiculopathy. Dr. Greenfield also noted that appellant had degenerative disc disease at L3-4, L4-5 and L5-S1. He diagnosed a normal L2-3 intervertebral disc, a posterior with bulging discs with Grade 5 annular disruptions at L3-4 and L4-5, and degenerative disc disease at L3-4, L4-5 and L5-S1. In a July 5, 2005 report, Dr. Greenfield diagnosed intervertebral disc disorders, lumbar or lumbosacral intervertebral disc and lumbar radiculopathy. He recommended L4-5 and L5-S1 percutaneous discectomy.

In a July 11, 2005 report, Dr. Katta noted that on examination appellant walked without any gait deviation, although she continued to have painfully limited movements of her thoracolumbar spine at the extremes. He advised that straight leg raising was negative bilaterally, and that appellant continued to have localized tenderness to palpation over the thoracic and lumbar paraspinal muscles extending over the sacroiliac joint area with relative weakness of the lower back muscles and painfully limited movements of her thoracolumbar spine. Dr. Katta indicated that appellant had normal muscle strength in both upper and lower extremities and deep tendon reflexes were "2+" and symmetrical. He also noted that appellant remained independent with her mobility. Dr. Katta diagnosed chronic thoracolumbar sprain with radiological evidence of degenerative joint disease of lumbar vertebrae and degenerative joint disease of both knees and degenerative meniscal tears of both knees, and degenerative disc disease involving T7, T8 and T8-9.

On July 12, 2005 the Office received a request to authorize a percutaneous discectomy at L4-5 and L5-S1.

In a July 31, 2005 report, an Office medical adviser noted appellant's history and opined that "there is no recognizable medical condition affecting the L5-S1 disc based on the definitive myelogram with computerized axial tomography (CAT) scan follow up performed on February 23, 2004 or the lumbar MRI scan dated October 23, 2003." He further advised that there was no evidence of lumbar radiculopathy, plexopathy, myopathy or neuropathy. The Office medical adviser noted that the June 21, 2005[4] discogram revealed that, at L4-5 and L5-S1, appellant had low back pain at both levels and at the L5-S1 level and bilateral hip pain, a posterior bulging disc with a degenerative pattern at L4-5 and at L5-S1 a diffuse spread pattern with associated posterior protrusion. He noted that Dr. Greenfield disregarded the normal findings at L4-5 in the earlier lumbar MRI scan with computerized tomography (CT) scan, and recommended percutaneous disc decompressions at L4-5 and L5-S1. The Office medical adviser explained that in his July 11, 2005 report Dr. Katta related that appellant walked into his office without any gait deviation, that her straight leg raisings were negative bilaterally, and that her lower and upper extremity strength was normal. He explained that the only report that supported

[4] While he indicated January 21, 2005, this appears to be a typographical error, as it is actually June 21, 2005.

the procedure was the lumbar discography; however, the lumbar MRI scan and the myelogram with CT scan follow up did not demonstrate any abnormalities. The Office medical adviser recommended that the two level lumbar percutaneous disc compression not be authorized. He explained that, if a lumbar disc were to consequentially be accepted, it would have to be at the L3-4 level, above the accepted level. The Office medical adviser explained that it was generally accepted in lumbar spine conditions that disc levels above an injured level could be at an increased risk from wear and tear as a result of splinting and increased mobility needs at the next higher level. However, he explained that this would not apply to a lower level, because of the pathology directly above causing substantially fewer demands for movement.

By decision dated August 8, 2005, the Office denied appellant's claim for a consequential L5-S1 condition and authorization for a percutaneous discectomy. The Office found that the medical evidence was insufficient to establish that her L5-S1 condition was a consequence of the accepted injury or that the accepted condition necessitated the need for surgery.

By letter dated September 27, 2005, appellant requested reconsideration.[5] In a January 5, 2005 lumbar spine MRI scan, Dr. Dipak C. Shah, a Board-certified radiologist, noted findings including postsurgical changes in the soft tissues posterior to the posterior elements of the L4 vertebra, a left foraminal disc protrusion and posterior osteophyte formation at the level of the L4-5 intervertebral disc level, and degenerative arthritic changes in the facet joint of the L4-5 and L5-S1 vertebra. The scan revealed a bulging annulus at the L3-4 and L4-5 intervertebral disc levels, and a loss of normal signal from the L3-4 and L4-5 intervertebral disc, which represented degenerative changes. Dr. Shah explained that the combination of disc protrusion and posterior osteophyte formation in the left foraminal region of the L4-5 intervertebral disc level caused encroachment of the left neural foramina at the L4-5 intervertebral disc level. He noted degenerative arthritic changes in the facet joint of the L4-5 and L5-S1 vertebra, a bulging annulus at the L3-4 and L4-5 intervertebral disc levels, and a loss of normal signal from the L3-4 and L4-5 intervertebral discs which were degenerative.

In an August 24, 2005 report, Dr. Greenfield indicated that appellant had a history of low back pain and bilateral radicular pain, previous refractory for multiple treatment modalities. He advised that appellant underwent discography on June 21, 2005. Dr. Greenfield determined that she had discogenic pain at L5-S1 greater than at L4-5. He again recommended that appellant undergo an L4-5 and L5-S1 percutaneous disc compression.

By decision dated October 20, 2005, the Office denied modification of the August 8, 2005 decision.

In a December 27, 2004 report, Dr. Holladay noted that appellant related that she had pain in both legs, her back and thigh. He conducted a physical examination and advised that her motor, sensory and reflex examinations were unremarkable with the exception of positive straight leg raising with back and leg pain bilaterally. Dr. Holladay recommended an MRI scan. In an October 10, 2005 report, Dr. Katta advised that appellant walked without any obvious gait deviation, although he noted that she had painfully limited movements of her thoracolumbar spine at the extremes. He diagnosed chronic thoracolumbar sprain with radiological evidence of

[5] Appellant withdrew her August 11, 2005 request for a hearing.

degenerative joint disease of the lumbar vertebrae and indicated that there was evidence of degenerative disc disease involving the thoracic vertebrae.[6]

On December 10, 2005 appellant requested reconsideration. She submitted an October 27, 2005 report from Dr. Greenfield who noted that she had a history of back pain with leg pain dating to January 2002. Dr. Greenfield stated that previous diagnostic tests revealed discogenic disease, including degenerative disc disease and disc protrusion at L4-5 and facet joint changes in the lower lumbar and lumbosacral spine. He indicated that discogenic pain was identified at L4-5 and L5-S1. Dr. Greenfield opined that "it would appear that the discogenic pain at L4-5 and L5-S1 [were] intimately related." He advised that appellant would be a good candidate for percutaneous disc decompression to treat her discogenic pain. In a November 3, 2005 report, Dr. Greenfield diagnosed cervical radiculopathy and performed a cervical epidural nerve block with steroid augmentation.

In a January 9, 2006 treatment note, Dr. Katta reiterated his previous diagnoses. A January 5, 2005 EMG and nerve conduction study was read by Dr. Fariz Habib, a Board-certified neurologist, as normal. It showed no evidence of entrapment neuropathy in the upper extremities, peripheral neuropathy, cervical radiculopathy or myopathy. Dr. Habib noted that tendinitis, cumulative injury syndrome or overuse syndrome, may have contributed to the current symptomatology. The Office also received a copy of Dr. Greenfield's June 21, 2005 lumbar discogram, and treatment notes dated October 13, 2004 and June 2, 2005, from Dr. William Bohn, a Board-certified orthopedic surgeon, who noted appellant's history and diagnosed chronic rotator cuff tendinitis and bursitis with impingement of the left shoulder. Dr. Bohn also diagnosed chronic cervical strain and opined that appellant had impairment related to her cervical spine, which "appears to all be related to the elevator accident." The Office also received treatment notes from Dr. Jones, dated August 23 and October 11, 2004, which contained a diagnosis of lumbar radiculopathy.

By decision dated April 18, 2006, the Office denied modification of its October 20, 2005 decision.

LEGAL PRECEDENT

The general rule respecting consequential injuries is 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, which is attributable to the employee's own intentional conduct.[7] The subsequent injury is compensable if it is the direct and natural result of a compensable primary injury.[8] With respect to consequential injuries, the Board has stated that, where an injury is sustained as a consequence of an impairment residual to an employment injury, the new

[6] He also diagnosed degenerative joint disease of both knees with degenerative meniscal tears of both knees.

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

[8] *Id.; Carlos A. Marrero*, 50 ECAB 117 (1998); A. Larson, *The Law of Workers' Compensation* § 10.01 (2005).

or second injury, even though nonemployment related, is deemed, because of the chain of causation to arise out of and in the course of employment and is compensable.[9]

Section 8103(a) of the Federal Employees' Compensation Act provides that 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 Office considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of the monthly compensation.[10] The Office has the general objective of ensuring that an employee recovers from his injury to the fullest extent possible in the shortest amount of time. The Office therefore has broad administrative discretion in choosing means to achieve this goal. The only limitation on the Office's authority is that of reasonableness. Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment, or actions taken which are contrary to both logic and probable deductions from established facts. It is not enough to merely show that the evidence could be construed so as to produce a contrary factual conclusion.[11]

In order for a surgery to be authorized, a claimant must submit evidence to show that the requested procedure is for a condition causally related to the employment injury and that it is medically warranted. Both of these criteria must be met in order for the Office to authorize payment.[12]

ANALYSIS

Appellant sustained injury on January 7, 2002 accepted for a lumbar strain for which she underwent surgery at L4-5. The Office also accepted bilateral knee conditions related to her fall. The Board finds that appellant submitted insufficient medical evidence to establish a consequential L5-S1 condition or necessity for an L5 and L5-S1 percutaneous discectomy due to residuals of her January 7, 2002 employment injury.

The Office received several reports from Dr. Holladay. In a January 8, 2004 report, Dr. Holladay stated that the exacerbation of lumbar strain was "perhaps" due to problems with her knees, or because of the degenerative disease. The Board has held that an opinion which is speculative in nature has limited probative value in determining the issue of causal relationship.[13] Other reports submitted by Dr. Holladay, did not provide any opinion on causal relationship. Medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[14]

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[9] *Kathy A. Kelley*, 55 ECAB 206 (2004).

[10] 5 U.S.C. § 8103(a).

[11] *Francis H. Smith*, 46 ECAB 392 (1995); *Daniel J. Perea*, 42 ECAB 214 (1990).

[12] *Cathy B. Mullin*, 51 ECAB 331 (2000).

[13] *Arthur P. Vliet*, 31 ECAB 366 (1979).

[14] *Michael E. Smith*, 50 ECAB 313 (1999).

The Office also received several reports from Dr. Katta dating from March 2004 to January 2006. However, Dr. Katta's reports are of limited probative value as they noted that appellant's condition was degenerative. He determined that appellant's chronic lower back pain resulted from her degenerative disc disease. Dr. Katta opined that there was no clinical evidence of ongoing lumbar radiculopathy and provided no reasoned opinion supporting that the claimed L5-S1 condition was a direct and natural result of the January 7, 2002 work injury. In his July 11 and October 2005 reports, Dr. Katta noted that, on physical examination, appellant walked in without any gait deviation, despite having limited movements of her thoracolumbar spine. Dr. Katta again attributed her condition to degenerative joint disease of lumbar vertebrae and thoracic vertebrae.

Dr. Greenfield advised that appellant was unable to move after cleaning her house the previous day. This report did not contain any opinion on causal relation. In an October 27, 2005 report, Dr. Greenfield noted that appellant had a history of back pain dating back to January 2002, and that she had degenerative disc disease and discogenic pain at L4-5 and L5-S1. He opined that "it would appear that the discogenic pain at L4-5 and L5-S1 [were] intimately related" and recommended percutaneous disc decompression. However, Dr. Greenfield's opinion on causal relation is speculative in nature. The Board has held that medical opinions that are speculative or equivocal in character are of diminished probative value.[15] Dr. Greenfield did not otherwise provide any medical reasoning or rationale to support his opinion on causal relationship.[16] Other reports submitted by Dr. Greenfield, did not provide any opinion on causal relationship. For example, his June 21, 2005 report diagnosed a posterior with bulging discs with Grade 5 annular disruptions at L3-4 and L4-5 and degenerative disc disease at L3-4, L4-5 and L5-S1 but he did not discuss causal relationship.

The reports of diagnostic testing submitted by appellant are insufficient to establish the claim as they did not provide any opinion supporting that appellant had an L5-S1 condition as a consequence of the accepted condition. The record also contains numerous reports from physical therapists. However, health care providers such as physical therapists are not physicians under the Act. Thus, their opinions on causal relationship do not constitute rationalized medical opinions and have no weight or probative value.[17]

The Office medical adviser, in a report dated July 31, 2005, concluded that the condition and procedures should not be authorized and explained that "there is no recognizable medical condition affecting the L5-S1 disc based on the definitive myelogram with CAT scan follow up performed on [February 23, 2004] or the lumbar MRI scan dated [October 23, 2003]." He noted that, while the June 21, 2005 discogram revealed low back pain at both L4-5 and L5-S1, he advised that there was also a degenerative pattern at these levels. The Office medical adviser explained that, despite normal findings at L4-5 in the earlier lumbar MRI scan, Dr. Greenfield recommended percutaneous disc decompressions at L4-5 and L5-S1. Additionally, the Office

[15] *Kathy A. Kelley*, 55 ECAB 207 (2004).

[16] *See George Randolph Taylor*, 6 ECAB 986, 988 (1954) (where the Board found that a medical opinion not fortified by medical rationale is of little probative value).

[17] *Jan A. White*, 34 ECAB 515, 518 (1983).

medical adviser explained that, on July 11, 2005, Dr. Katta related that appellant walked into his office without any gait deviation, and indicated that her straight leg raisings were negative bilaterally, and that her lower and upper extremity strength was normal. He noted that the only report tending to support a need for the procedure was the lumbar discography; however, because the MRI scan and CT scan follow up did not demonstrate any abnormalities, he did not recommend authorizing the two level lumbar percutaneous disc compression. Furthermore, Dr. Katta explained that, in lumbar spine conditions, disc levels above an injured level could be at an increased risk from wear and tear as a result of splinting and increased mobility needs at the next higher level. The medical adviser explained that this would not apply in appellant's case where the claimed consequential injury was to a lower level where there would be substantially fewer demands for movement.

In this case, there is insufficient medical evidence of record to establish a causal relationship between appellant's L5-S1 condition and request for percutaneous discectomy and the accepted work-related incident. An award of compensation may not be based on appellant's belief of causal relationship.[18] 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 a causal relationship.[19] The Board, therefore, finds that the evidence of record is insufficient to discharge her burden of establishing that her consequential L5-S1 condition and need for surgery were consequential injuries of the accepted condition of lumbar strain and lumbar microdisc surgery at L4-5.[20]

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that her L5-S1 condition and the requested authorization for an L5 and L5-S1 percutaneous discectomy was a consequence of her accepted conditions.

[18] *Dennis M. Mascarenas*, 49 ECAB 215, 218 (1997).

[19] *Id.*

[20] On appeal appellant submitted additional medical evidence. However, the Board may not consider new evidence for the first time on appeal. *See* 20 C.F.R. § 501.2(c).

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated April 18, 2006 and October 20 and August 8, 2005 are affirmed.

Issued: March 26, 2007
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

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