United States Department of Labor
Employees' Compensation Appeals Board

C.S., Appellant	)	
and	)	**Docket No. 13-1409**
	)	**Issued: March 19, 2014**
DEPARTMENT OF THE ARMY, TRAINING & DOCTRINE COMMAND, Kandahar Province, Afghanistan, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On May 28, 2013 appellant filed a timely appeal from a February 28, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 an employment-related injury on July 14, 2012.

On appeal, appellant asserts that employment factors caused a stroke, back injury and pseudobulbar affect.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On August 9, 2012 appellant, then a 58-year-old social scientist, filed a traumatic injury claim, alleging that on July 14, 2012 he sustained mono peripheral neuropathy of the lower left leg and foot. He indicated that, while in full combat gear, carrying a heavy pack and after sitting for 45 minutes on a dirt road at a remote location, when he stood his left foot was numb and he could not walk normally which caused him to fall several times. A witness, Asif Mohammadi, an Army interpreter, indicated that on July 14, 2012 he was sitting with appellant, translating, and when appellant rose, he fell down and had trouble walking the rest of the day.

In a July 20, 2012 report, Dr. Jason Bennett, an Army staff internist at Forward Operating Base Pasab (FOB Pasab), described a history that appellant lost motor control in his left foot six days earlier and had fallen several times. Appellant was seen by a medic and a brigade surgeon who recommended that he see a physician at the forward base. Dr. Bennett reported that the foot paresthesias had improved but there had been no motor function improvement. The head, neck, eyes, lungs and cardiovascular system were normal. Musculoskeletal examination demonstrated no left foot erythema, abnormal warmth or tenderness on palpation. Neurological examination revealed decreased response to tactile stimulation of the left leg and foot. Motor examination showed dysfunction of the left foot demonstrated by difficulty walking on toes and decreased strength. Peripheral nerve examination revealed decreased sensation over L5-S1 on the left. Dr. Bennett diagnosed peripheral neuropathy, likely secondary to peripheral compression. He indicated that appellant denied back injury, had no radicular symptoms originating in the back and no back pain or red flags that would require emergency evacuation. Dr. Bennett recommended waiting two weeks to determine if appellant further improved and, if not, evaluate for further studies. On July 30, 2012 Jess Feldtmann, a physical therapist, reported appellant's history and indicated that weakness was his primary complaint and that he reported several episodes of shooting pain from the buttock to the foot. On August 12, 2012 he noted no improvement and stated that, after discussion with Dr. Bennett, appellant would be evacuated for a neurology consult.

By letter dated August 22, 2012, OWCP informed appellant of the type of evidence needed to support his claim. Appellant submitted an August 11, 2012 report in which Dr. Josh L. Duckworth, a Navy neurologist, reported a history that appellant sustained acute left lower extremity compression neuropathy on July 14, 2012. Dr. Duckworth indicated that appellant's sensory loss had improved slightly but that he had no appreciable recovery of motor function. He further indicated that appellant reported an event when he woke from sleep with pain throughout his entire left leg. Examination of the left lower extremity demonstrated decreased sensation. Dr. Duckworth diagnosed idiopathic peripheral neuropathy, noting that appellant had left leg and foot sensory loss and weakness without clinical symptoms to suggest localization to the L5 or S1 nerve root or sciatic injury. He opined that this was possibly a compression mechanism with mild thrombotic thrombocytopenic purpura of the popliteal fossa that resulted in both peroneal and tibial nerve injury. Further he indicated that peroneal weakness and sensory deficit would suggest greater nerve root involvement. Dr. Duckworth ordered electrodiagnostic and lumbar magnetic resonance imaging (MRI) scan studies.

In a September 5, 2012 report, Dr. V. Nanda Kumar, a Board-certified physiatrist, reported the history of injury as described by appellant and his complaints of occasional back, buttock and thigh discomfort on the left. Lumbar spine range of motion was reduced. Range of

motion of the hips, knees and ankles was normal. Dr. Kumar noted definite weakness in the dorsiflex of the left foot and sensory loss in the medial aspect of the left and foot. He reported that lower extremity electrodiagnostic studies showed L5 radiculopathy.[2] Dr. Kumar recommended a lumbar spine MRI scan study. A September 11, 2012 lumbar MRI scan revealed varying degrees of disc desiccation throughout the thoracolumbar spine; disc space narrowing at L5-S1; disc bulges at L3-4 and L4-5 which effaced/abutted the anterior aspect of the thecal sac; mild facet arthrosis at L3-4 through L5-S1; and no focal disc protrusion, extrusion, central canal stenosis or neural foraminal encroachment.

In an undated report, Dr. Megan Childs, a Board-certified internist and Army physician, advised that appellant had limited range of motion when walking and was unable to meet the physical requirements needed for deployment.

By decision dated September 26, 2012, OWCP found the evidence insufficient to establish that the events occurred as described and denied the claim on the grounds that appellant had not established fact of injury.

On December 27, 2012 appellant requested reconsideration. In statements dated December 27, 2012 and January 13, 2013, he described the events of July 14, 2012 and indicated that, because he was in a highly combative war zone, he could not immediately be transported to medical facilities and had to wait one week for an armored convoy to transport him to FOB Pasab where he was examined by Army doctors. Appellant stated that he was then evacuated to an Army hospital at Fort Leavenworth, Kansas, but, because he was a civilian, he was referred for civilian medical care and was permanently released by the employing establishment on October 28, 2012 because his left foot prevented him from returning to the Afghanistan combat zone. He also indicated that he had a stroke on July 14, 2012 caused by dehydration with a permanent brain injury that caused paralysis of his left leg and foot and further suffered from post-traumatic stress disorder due to his work in combat.

On October 3, 2012 Colonel Mark T. Stevens noted being appellant's direct supervisor in Afghanistan. Until July 14, 2012 appellant conducted his normal duties of accompanying soldiers on patrols and had no limiting medical conditions. Mr. Stevens indicated that on July 14, 2012 appellant was assigned to Hutal, a base 20 miles from FOB Pasab, which had only a medic and no physicians or nurses. Army personnel were required to travel in armored vehicle convoys and appellant had to wait several days for transport to FOB Pasab for medical treatment. Mr. Stevens observed that appellant walked with a limp and could not flex his left foot. On August 10, 2012 appellant was transported by helicopter to Kandahar Airfield where he was examined and was then transported to the United States, arriving August 15, 2012.

On October 8, 2012 Priscilla A. Tacujan, Ph.D., reported that she was appellant's coworker in Afghanistan. She noted accompanying him to the base at Hutal in July 2012 but was not on patrol with him on July 14, 2012. Dr. Tacujan saw appellant when he returned from patrol and noted that he walked with a limp with restricted left foot movement.

In an October 19, 2012 attending physician's report, Dr. Childs noted a history of injury of sudden onset lower back pain and lower leg numbness and weakness. She diagnosed L5

[2] A copy of the electrodiagnostic study report is not found in the case record before the Board.

radiculopathy based on electrodiagnostic studies, L3-4 and L4-5 disc bulges on MRI scan study, and gait abnormality and checked a form box "yes" that appellant's condition was work related, stating that there was no radiographic evidence of abnormality or neurologic symptoms prior to injury. Dr. Childs indicated that appellant was totally disabled from July 14 to October 14, 2012 and could return to office work as tolerated by pain, as of September 17, 2012.

In an October 19, 2012 treatment note, Dr. Sreenadha R. Davuluri, a Board-certified internist and neurologist, noted a history of a work injury in Afghanistan that caused limited left foot motion. Physical examination demonstrated diminished ankle jerks. Dr. Davuluri diagnosed lumbar radiculopathy, left leg numbness and weakness and recommended MRI scan and magnetic resonance angiogram (MRA) studies of the brain. In a November 12, 2012 report, he noted appellant's report of mid to low back pain and that his left foot drop was better. Dr. Davuluri indicated that the MRI scan study showed micro ischemic changes and that an MRA study was normal.[3] He diagnosed cerebrovascular disease.

In a January 15, 2013 report, Dr. Paul M. Joslin, a Board-certified internist, noted a history of onset of left leg weakness and paresis on July 14, 2012. His November 16, 2012 examination showed subtle left leg weakness and foot drop which had resolved by his January 15, 2013 examination. Dr. Joslin reviewed the diagnostic studies including the lumbar spine MRI scan and noted that serologic tests, done to rule out infectious disease, were normal. He described the findings in Dr. Davuluri's November 12, 2012 report. Dr. Joslin diagnosed left lower extremity paresis and numbness, lumbar radiculopathy and cerebrovascular disease. He opined that the lumbar radiculopathy was caused by a disc bulge related to carrying a 100-pound pack at work and that an ischemic cerebrovascular accident was due to dehydration, hypovolemia and heat, which were work related.

In a January 16, 2013 report, Dr. Joslin noted first seeing appellant on November 16, 2012 and again on January 15, 2013. Appellant described being on patrol in Afghanistan on July 14, 2012 and wearing an 80- to 100-pound pack in 120-degree heat. He sat down for about 45 minutes to have a discussion with a local and, upon standing, had marked weakness and numbness in the left leg and was only able to walk with a significant limp and was unsteady. Serial evaluations by field medics and at a local hospital led to appellant's transfer stateside and ultimately for a nonmilitary medical evaluation. Dr. Joslin advised that his November 16, 2012 examination showed subtle left lower extremity weakness and foot drop that improved by January 15, 2013, at which time he had no weakness, numbness or foot drop and a normal gait. He indicated that his medical opinion and explanation as to how the reported work incident caused or aggravated the medical conditions would include two possibilities, both related to appellant's work in Afghanistan. Dr. Joslin advised that first, appellant's left lower extremity weakness, numbness and foot drop were due to lumbar radiculopathy which would presumably be caused by disc bulging related to carrying an 80- to 100-pound pack. He opined that this would be a less likely explanation, in light of the absence of focal disc protrusion, spinal stenosis or foraminal encroachment on the MRI scan study and that the most likely explanation was that appellant's left lower extremity paresis, sensory deficit and foot drop were caused by an ischemic cerebrovascular accident in the right middle cerebral artery distribution, due to dehydration and hypovolemia in combination with extreme heat while on patrol in Afghanistan.

[3] Copies of the MRI scan and MRA study reports are not found in the case record before the Board

Dr. Joslin concluded that appellant was fortunate to have recovered completely as of his examination on January 15, 2013.

In a merit decision dated February 28, 2013, OWCP found that the record established that it was extremely hot in Hutal, Afghanistan on July 14, 2012, the date of injury, but denied the claim on the grounds that the medical evidence was insufficient to establish causal relationship.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of establishing the essential elements of his or her claim including the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was timely filed within the applicable time limitation period of FECA, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury. Regardless of whether the asserted claim involves traumatic injury or occupational disease, an employee must satisfy this burden of proof.[4]

OWCP regulations, at 20 C.F.R. § 10.5(ee) define a traumatic injury as a condition of the body caused by a specific event or incident or series of events or incidents within a single workday or shift.[5] To determine whether an employee sustained a traumatic injury in the performance of duty, OWCP must determine whether "fact of injury" is established. First, an employee has the burden of demonstrating the occurrence of an injury at the time, place and in the manner alleged, by a preponderance of the reliable, probative and substantial evidence. Second, the employee must submit sufficient evidence, generally only in the form of medical evidence, to establish a causal relationship between the employment incident and the alleged disability and/or condition for which compensation is claimed. An employee may establish that the employment incident occurred as alleged, but fail to show that his or her disability and/or condition relates to the employment incident.[6]

Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[7] 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 medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[8] 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.[9]

[4] *Gary J. Watling*, 52 ECAB 278 (2001).

[5] 20 C.F.R. § 10.5(ee); *Ellen L. Noble*, 55 ECAB 530 (2004).

[6] *Supra* note 4.

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

[8] *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

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

ANALYSIS

The Board finds that this case is not in posture for decision. The issue in this case is whether appellant met his burden of proof to establish an employment injury on July 14, 2012.

It is accepted that on July 14, 2012 it was hot in Hutal, Afghanistan, that appellant was laden with body armor and a pack and that, after sitting for about 45 minutes, when he stood he had left lower extremity paresthesias and immobility of his left foot. It is also accepted that he could not receive medical care from a physician for a number of days due to his remote location that required waiting for a military convoy to transport him to a FOB for medical treatment and then further time passed until he was transferred stateside for further medical treatment.

Initial medical reports provided by appellant did not clearly address how incidents of July 14, 2012 caused a particular diagnosed condition. In the July 20, 2012 report, Dr. Bennett diagnosed peripheral neuropathy, likely secondary to peripheral compression, but did not explain how the July 14, 2012 incident caused the diagnosis. Dr. Duckworth, on August 11, 2012, described the history of injury and opined that appellant's condition was possibly a compression mechanism but did not specifically address how the July 14, 2012 incident caused any condition. Dr. Childs' October 19, 2012 attending physician's report gave some support for causal relationship, indicating that there was no radiographic evidence of abnormality or neurologic symptoms prior to injury; however, his report did not contain sufficient medical rationale to meet appellant's burden of proof.

In reports dated January 15 and 16, 2013, Dr. Joslin described appellant's report of the July 14, 2012 injury while working in Afghanistan. He described his physical examination findings on November 16, 2012 and January 15, 2013, noting that by the latter date appellant had recovered completely. Dr. Joslin provided some reasoning, explaining that there were two possible scenarios, both work related, for appellant's left lower extremity numbness, weakness and foot drop: that they were caused by lumbar radiculopathy from carrying a heavy pack while in Afghanistan or, more likely, that appellant suffered an ischemic cerebrovascular accident due to dehydration and hypovolemia on July 14, 2012.

The Board finds that, while Dr. Joslin's opinion lacks detailed medical rationale sufficient to discharge appellant's burden of proof that the events in Afghanistan on July 14, 2012 caused or aggravated appellant's back and left lower extremity condition, it is of sufficient probative value to require OWCP to further develop the medical evidence.[10] The Board is mindful of the difficulty appellant encountered to obtain medical treatment while being stationed in a remote location requiring military convoys for transport. There were gaps in medical treatment due to the unusual circumstances of where appellant suffered the incident. It was several days before he could seek treatment at a FOB and approximately a month before he was transferred to the United States for further medical treatment. The Board finds that Dr. Joslin's January 16, 2013 report is of sufficient probative value to require further development. The Board also notes that his opinion is uncontroverted.

It is well established that proceedings under FECA are not adversarial in nature and while the claimant has the burden to establish entitlement to compensation, OWCP shares

[10] *Shirley A. Temple*, 48 ECAB 404 (1997).

responsibility in the development of the evidence.[11] The case shall therefore be remanded to OWCP. On remand, it shall refer appellant, an updated statement of accepted facts and the medical evidence of record to an appropriate Board-certified specialist for an examination, diagnosis and a rationalized opinion as to whether he established that employment factors caused or aggravated his back or left lower extremity condition. After this and such further development deemed necessary, OWCP shall issue an appropriate decision.

As to appellant's argument on appeal regarding pseudobulbar affect, there is no medical evidence of record that indicates that he has been diagnosed with this condition.

CONCLUSION

The Board finds this case is not in posture for decision as to whether appellant sustained an employment-related injury on July 14, 2012.

ORDER

IT IS HEREBY ORDERED THAT the February 28, 2013 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded to OWCP for proceedings consistent with this opinion of the Board.

Issued: March 19, 2014
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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

[11] *See Jimmy A. Hammons*, 51 ECAB 219 (1999); *John J. Carlone*, 41 ECAB 354 (1989).