United States Department of Labor
Employees' Compensation Appeals Board

S.M., Appellant	)	
and	)	**Docket No. 15-1511**
	)	**Issued: January 11, 2016**
DEPARTMENT OF DEFENSE, DEPENDENTS EDUCATION, Arlington, VA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 6, 2015 appellant filed a timely appeal of a March 17, 2015 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.[2]

ISSUES

The issues are: (1) whether appellant met her burden of proof to establish that her claim should be expanded to include an L4-5 compression fracture; and (2) whether OWCP abused its discretion in denying authorization for kyphoplasty lumbar surgery.

[1] 5 U.S.C. § 8101 *et seq.*

[2] Appellant filed a timely request for oral argument. After exercising its discretion, by order dated October 5, 2015, the Board denied her request as her arguments could be adequately addressed in a decision based on a review of the case record. *Order Denying Request for Oral Argument*, Docket No. 15-1511 (issued October 5, 2015).

On appeal appellant contends there is an unresolved conflict in the medical opinion evidence requiring referral to an impartial medical examiner. She also contends that the second opinion physician's opinion is subjective and unsupported by the medical record.

FACTUAL HISTORY

This case has previously been before the Board. On March 18, 1996 appellant, then a 42-year-old personnel staffing assistant, filed a traumatic injury claim (Form CA-1) alleging that on March 15, 1996 she was involved in an elevator accident. She explained that due to mechanical failure the elevator in which she was riding fell from the sixth floor to between the fourth and fifth floors which caused cervical strain and multiple contusions to her hip, left thigh and leg, and lower spine. OWCP accepted the claim for lumbar sprain, left knee derangement, and chronic post-traumatic stress syndrome. Appellant stopped work on March 18, 1996 and was placed on the periodic rolls for temporary total disability by letter dated June 14, 1996. By decision dated April 7, 2000, the Board affirmed an OWCP hearing representative's decision dated April 1, 1998 and finalized on April 2, 1998, which affirmed a March 4, 1997 OWCP decision denying authorization for posterior spinal decompression for stenosis surgery performed on January 14, 1997 and epidural injections on October 24, November 1, and 19, 1996.[3] The facts and the circumstances of the case as set forth in the Board's prior decision are incorporated herein by reference.

Under OWCP File No. xxxxxx843, appellant had filed a Form CA-1 claim alleging that on September 13, 1991 she injured her foot, shin, and knee when she tripped over a telephone outlet. OWCP accepted the claim for bilateral knee contusions and a left old bucket handle tear of the medial meniscus and authorized left arthroscopic surgery, which was performed on December 23, 1991.[4] Under OWCP File No. xxxxxx370, appellant filed a Form CA-1 alleging that on October 5, 1993 she injured both knees when her shoe caught on a glue-like substance and she fell landing on her right knee and twisting her left leg. OWCP accepted the claim for right knee contusion and left ankle sprain, which was expanded to include right knee internal derangement. On June 21, 1994 OWCP combined OWCP File Nos. xxxxxx843 and xxxxxx370, the former number as the master file number. The conditions accepted by OWCP for the combined claims were lumbar sprain; chronic post-traumatic stress disorder; bilateral knee and leg sprains; bilateral/lateral meniscus derangement; lower leg arthropathy; knee contusion; bilateral old bucket handle medial meniscus tear; patellae chondromalacia; bilateral knee internal derangement; and ankle sprain; knee and lower leg contusion.

On January 23, 2008 OWCP authorized bilateral total knee replacement surgery, with the right knee surgery occurring on February 14, 2008 and the left knee surgery occurring on October 31, 2011.

[3] Docket No. 98-1715 (issued April 7, 2000).

[4] On February 1, 1993 OWCP granted appellant a schedule award for 24 percent permanent impairment of both knees. On July 11, 1995 it granted her a schedule award for an additional 36 percent permanent impairment of the right lower extremity.

Following the authorization of bilateral total knee replacement surgery, OWCP recommended combining OWCP File Nos. xxxxxx843 and xxxxxx370 with OWCP File No. xxxxxx421, with the latter as the master file on January 23, 2008.

On February 25, 2014 Dr. John W. Aldridge, a treating Board-certified orthopedic surgeon, reported that appellant was seen for low back pain. A review of a magnetic resonance imaging (MRI) scan revealed a new L4 fracture, lumbar spinal stenosis, and lumbar grade 1 spondylolisthesis involving the L4-5 vertebral body. Diagnoses included spinal stenosis, new L4 fracture, and acquired spondylolisthesis. Dr. Aldridge discussed the treatment options available to appellant and that L4 kyphoplasty surgery would be scheduled.

In a March 11, 2014 progress note, Dr. Aldridge diagnosed lumbosacral degenerative disc disease, lumbar spinal stenosis, and L4 fracture. He noted that appellant was seen for low back pain and leg weakness. Physical examination findings were provided including lumbar spine findings of no subluxations, no deformities or lesions, milder reduced range of motion with moderate pain, negative straight leg testing while supine and seated, and normal paraspinal muscle strength. Dr. Aldridge noted that appellant would undergo L4 kyphoplasty surgery.

OWCP received requests for authorization of kyphoplasty lumbar surgery after appellant had undergone the procedure on March 13, 2014. The postoperative diagnosis was listed as L4 osteoporotic pathologic compression fracture.

By letter dated April 4, 2014, OWCP informed appellant that it was currently unable to authorize the requested lumbar kyphoplasty procedure. It advised that a second opinion evaluation was necessary to determine whether the procedure should be authorized.

In an April 30, 2014 report, Dr. Charles Lancelotta, a second opinion Board-certified neurological surgeon, reviewed the statement of accepted facts and appellant's medical record. He related appellant's history of employment injuries and his own findings on physical examination. Dr. Lancelotta noted that review of a February 22, 2014 lumbar MRI scan showed a significant L4-5 compression fracture. He thereafter opined that the kyphoplasty surgery was warranted. However, Dr. Lancelotta explained that appellant's L4-5 large compression fracture was unrelated to her employment injuries. In support of this conclusion, he observed that appellant had no back problems following her March 15, 1996 employment injury and she had no significant back problems following her lumbar foraminotomy surgery in the early 1980's. Moreover, it appeared that the compression fracture was probably a result of her osteoporosis based on Dr. Aldridge's preoperative and postoperative diagnoses of L4 osteoporotic pathologic compression fracture. Dr. Lancelotta concluded that both appellant's osteoporosis and the L4-5 compression fracture were unrelated to the accepted employment injuries and that appellant had no neurosurgical problems or disability causally related to the accepted employment injuries.

By decision dated September 10, 2014, OWCP reissued a September 8, 2014 decision which denied appellant's request to expand her claim to include an L4-5 compression fracture as caused by the accepted injury or a consequence thereof. It also denied authorization for her kyphoplasty surgery.

In a letter dated November 5, 2014, appellant requested reconsideration. She argued that a bone density scan revealed that contrary to Dr. Lancelotta's opinion there was no evidence of osteoporosis. In support of her reconsideration request, appellant submitted a September 26, 2014 bone density scan from Riverside Health System which had been ordered by Dr. Dwight Herbert, a treating Board-certified family medicine practitioner. The bone density scan indicated that "[t]he bone mineral density of proximal femur is osteopenic, which has increased risk for fracture." On February 15, 2015 OWCP requested that Dr. Lancelotta review the September 26, 2014 bone density scan and provide an opinion as to whether this information changed his opinion regarding the kyphoplasty surgery.

On February 25, 2015 Dr. Lancelotta reviewed the September 26, 2014 bone density scan and opined that it had "nothing to do with [appellant's] lumbar compression fracture" as the scan was of the right proximal femur. Thus, his opinion remained unchanged.

By decision dated March 17, 2015, OWCP denied modification of its September 10, 2014 decision.

LEGAL PRECEDENT -- ISSUE 1

Where an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.[5] To establish a causal relationship between a claimed condition and the employment injury, an employee must submit rationalized medical evidence based on a complete medical and factual background supporting such a causal relationship.[6] Causal relationship is a medical issue and the medical evidence required to establish a causal relationship is rationalized medical evidence.[7] 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 diagnosed condition and the specific employment factors identified by the claimant.[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]

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 which is attributable to the employee's own intentional conduct. As is noted by Larson in his treatise on workers' compensation, once the work-connected character of any injury has been established, the subsequent progression of that condition

[5] *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[6] *M.W.*, 57 ECAB 710 (2006); *John D. Jackson*, 55 ECAB 465 (2004).

[7] *D.E.*, 58 ECAB 448 (2007); *Mary J. Summers*, 55 ECAB 730 (2004).

[8] *Phillip L. Barnes*, 55 ECAB 426 (2004); *Leslie C. Moore*, 52 ECAB 132 (2000).

[9] *V.W.*, 58 ECAB 428 (2007); *Ernest St. Pierre*, 51 ECAB 623 (2000).

remains compensable so long as the worsening is not shown to have been produced by an independent nonindustrial cause and so long as it is clear that the real operative factor is the progression of the compensable injury, associated with an exertion that in itself would not be unreasonable under the circumstances.[10]

ANALYSIS -- ISSUE 1

As a result of all of appellant's claims, OWCP has accepted the conditions of lumbar sprain; chronic post-traumatic stress disorder; bilateral knee and leg sprains; bilateral lateral meniscus derangement; lower leg arthropathy; knee contusion; bilateral old bucket handle medial meniscus tear; ankle sprain; knee and lower leg contusion; patellae chondromalacia; and bilateral knee internal derangement as caused by her combined accepted employment injuries. Appellant requested that her claim be expanded to include an L4-5 compression fracture. The issue on appeal is whether appellant met her burden of proof to establish that this condition is causally related by direct causation or as a consequential injury. The Board finds that she failed to meet her burden of proof.

Based on a clinical examination, review of the medical record, and statement of accepted facts, Dr. Lancelotta, the second opinion physician, opined that the medical record did not establish that the L4-5 compression fracture was causally related to appellant's employment injuries. He explained that appellant had no back problems following her March 15, 1996 employment injury or any significant back problems following her early 1980's lumbar foraminotomy surgery. Dr. Lancelotta further explained that, based on the postoperative diagnosis of L4 osteoporotic pathologic compression fracture, the lumbar fracture was due to appellant's osteoporosis. He opined that appellant's L4-5 compression fracture was not employment related as it was due to a condition that OWCP had not accepted.

In a February 25, 2015 supplemental report, Dr. Lancelotta reviewed a September 26, 2014 bone density scan at OWCP's request and indicated that his opinion remained unchanged. He explained that the bone density scan was of appellant's right proximal femur and had nothing to do with her lumbar compression fracture.

The Board finds that OWCP properly accorded the weight of the evidence to the medical opinion of Dr. Lancelotta. Dr. Lancelotta's report contains an extensive review of the medical record, discusses appellant's employment injury and medical history and supports his opinion with reasoning in both reports.[11] His opinion supports OWCP's finding that appellant has not established that her L4-5 fracture was directly caused by her employment injuries, or that it was a natural consequence of the progression of an accepted condition.

In support of her claim, appellant submitted reports from her treating physician, Dr. Aldridge diagnosing lumbosacral degenerative disc disease, lumbar spinal stenosis, and L4 fracture and recommending L4 kyphoplasty surgery. Dr. Aldridge provided physical examination findings and reviewed an MRI scan. However, he offered no opinion as to the

[10] *J.C.*, Docket No. 15-841 (issued August 3, 2015).

[11] *See James Mack*, 43 ECAB 321 (1991).

cause of appellant's L4 fracture. The Board has held that medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[12]

Appellant also submitted a September 24, 2014 bone density scan from Dr. Herbert which indicated that appellant was at an increased risk for fracture.

On appeal appellant argues that Dr. Lancelotta's opinion is unsupported by the factual and medical evidence. She also argues that his opinion that she has osteoporosis is unsupported by any medical test and the record as a whole. Lastly, appellant argues that there is an unresolved conflict in the medical opinion evidence between Dr. Lancelotta and her treating physicians, Drs. Aldridge and Herbert. As discussed above, the medical evidence does not establish that appellant's lumbar fracture is causally related to her employment injuries or a consequential injury. Contrary to appellant's arguments, Dr. Lancelotta provided a well-rationalized opinion explaining why her lumbar fracture was not employment related.

The Board finds that appellant has not met her burden of proof to establish any additional condition causally related to her accepted work injury. Therefore, OWCP properly denied her request to expand her claim to include L4-5 fracture.

LEGAL PRECEDENT -- ISSUE 2

Section 8103 of FECA[13] 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 OWCP considers likely to cure, give relief, reduce the degree or the period of disability, or aid in lessening the amount of the monthly compensation.[14] In interpreting section 8103, the Board has recognized that OWCP has broad discretion in approving services provided under FECA.[15] The only limitation on OWCP's authority is that of reasonableness.[16] 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.[17]

[12] *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *J.F.*, Docket No. 09-1061 (issued November 17, 2009); *A.D.*, 58 ECAB 149 (2006).

[13] 5 U.S.C. § 8101 *et seq.*

[14] 5 U.S.C. § 8103; *see R.L.*, Docket No. 08-855 (issued October 6, 2008); *Sean O'Connell*, 56 ECAB 195 (2004), *Thomas W. Stevens*, 50 ECAB 288 (1999).

[15] *A.O.*, Docket No. 08-580 (issued January 28, 2009); *Joseph P. Hofmann*, 57 ECAB 456 (2006).

[16] *D.C.*, 58 ECAB 620 (2007); *Dr. Mira R. Adams*, 48 ECAB 504 (1997).

[17] *L.W.*, 59 ECAB 471 (2008); *P.P.*, 58 ECAB 673 (2007); *Daniel J. Perea*, 42 ECAB 214 (1990).

ANALYSIS -- ISSUE 2

OWCP accepted the conditions of chronic post-traumatic stress disorder; bilateral knee and leg sprains; bilateral lateral meniscus derangement; lower leg arthropathy; knee contusion; bilateral old bucket handle medial meniscus tear; lumbar sprain; ankle sprain; knee and lower leg contusion; patellae chondromalacia; and bilateral knee internal derangement.

Appellant requested authorization for L4 kyphoplasty surgery. In reports dated February 25 and March 11, 2014, Dr. Aldridge diagnosed a new L4 fracture, spinal stenosis, lumbar degenerative disc disease, and acquired spondylolisthesis. He asserted that a lumbar spine MRI scan showed a new L4 fracture, lumbar spinal stenosis, and lumbar grade 1 spondylolisthesis involving the L4 vertebral body. Dr. Aldridge recommended surgery. However, the Board notes that he provided no opinion as to how the recommended surgery was due to the accepted employment conditions. Dr. Lancelotta, a second opinion Board-certified neurologist, explained that the surgery was not due any accepted conditions, but was due to nonemployment-related osteoporosis. Appellant did not provide any further medical evidence to support or clarify the need for the requested surgery.

Based on the evidence of record, OWCP reasonably concluded that the proposed surgery was not warranted. It did not abuse its discretion in denying authorization for the kyphoplasty surgery in this case.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant did not meet her burden of proof to establish that her claim should be expanded to include an L4-5 compression fracture. The Board further finds that OWCP did not abuse its discretion when it denied authorization for kyphoplasty lumbar surgery.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 17, 2015 is affirmed.

Issued: January 11, 2016
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board