United States Department of Labor
Employees' Compensation Appeals Board

A.W., Appellant	)	
and	)	**Docket No. 17-1015**
	)	**Issued: November 2, 2017**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Pittsburgh, PA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On April 10, 2017 appellant, through counsel, filed a timely appeal from a February 13, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant met his burden of proof to establish an injury causally related to an accepted June 22, 2015 employment incident.

FACTUAL HISTORY

On July 29, 2015 appellant, then a 57-year-old food service worker, filed a traumatic injury claim (Form CA-1) alleging that on June 22, 2015 he strained his lower back when he slipped on spilt coffee and fell while getting exiting an elevator at work. The claim form did not indicate whether he stopped work.

Appellant was initially treated in the emergency room by Dr. Daniel R. Kievlan, Board-certified in emergency medicine, who related in a June 22, 2015 critical care note, that appellant slipped on liquid and fell at work outside of the main elevators. Dr. Kievlan indicated that appellant had a history of lumbar spinal stenosis and spondylolisthesis. Examination of appellant's lumbar spine showed no tenderness to palpation. Dr. Kievlan reported decreased sensation to light touch in the left lower extremities, but normal sensation in all other extremities. He diagnosed mechanical fall and left lower extremity weakness/numbness, likely exacerbation of chronic spinal stenosis/spondylolisthesis.

In a June 22, 2015 hospital record, Dr. Palaniswamy Sundaram, a Board-certified internist, indicated that appellant slipped and fell on fluid outside of an elevator at work around 10:45 a.m. and experienced back, left hip, and left thigh pain. He noted that appellant had a significant history for lumbar spinal stenosis with chronic back pain. Upon physical examination Dr. Sundaram reported tenderness over the lower lumbar area, left lateral hip, and lateral aspect of the left knee. He diagnosed accidental fall with left thigh contusion and exacerbation of chronic low back pain.

Appellant underwent a series of diagnostic scans and examinations. In a June 22, 2015 lumbar spine computerized tomography (CT) scan report, Dr. Scott A. Lapidus, a radiologist, noted visualized vertebral bodies that were normal in height and alignment and well-preserved disc spaces. In a June 22, 2015 pelvis CT scan, Dr. Wendy W. Rhoads, a Board-certified diagnostic radiologist, indicated that appellant complained of low back pain and left hip tenderness after an accidental fall. She reported degenerative changes of the sacroiliac joints and bilateral hip joints and facet arthropathy in the visualized lumbar spine. In a June 22, 2015 lumbar spine radiology report, Dr. Vidhi A. Gupta, a Board-certified diagnostic radiologist, reported normal vertebral body heights and decreased disc space at L4-5, T12-L1 level and osteophytes and facet hypertrophy. She diagnosed degenerative disease and no evidence of instability. In a left femur and knee radiology report, Dr. Gupta indicated that appellant fell and complained of left knee and thigh pain. She noted no evidence of acute osseous trauma and mild degenerative disease in the knee.

Dr. David Suski, Board-certified in emergency medicine, treated appellant on July 13, 2015 in the emergency room and noted that appellant had a known history of back pain. He related that a recent lumbar spine magnetic resonance imaging (MRI) scan showed multilevel disc disease and narrowing of the central canal and bilateral neural foraminal narrowing.

Dr. Suski noted that appellant sustained a slip and fall accident at work on June 22, 2015 and was off work for five days before returning to work. He reported that appellant now complained that his back pain had flared up and was too much for him to continue working. Upon physical examination of appellant's lumbar spine, Dr. Suski reported no thoracic spine tenderness to palpation and diffuse lumbar spine tenderness to palpation. Neurological examination of the lower extremities showed intact strength. Dr. Suski diagnosed acute chronic lumbar pain. He reported that appellant had a known history of lumbar disc disease and had a recent fall on June 22, 2015. Dr. Suski recommended that appellant remain off work for two days.

In an August 12, 2015 progress note, Dr. Deepika Pasunur, a Board-certified internist, related appellant's complaints of low back pain after he slipped and fell in front of the elevator at work on June 22, 2015. She noted that he had stopped work and returned two weeks ago, but now complained that he could not tolerate the pain. Dr. Pasunur indicated that appellant was scheduled for lumbar fusion surgery on September 25, 2015. Examination of appellant's lumbar spine showed no tenderness and positive straight leg raise testing in the bilateral lower extremities. Dr. Pasunur reported that examination of appellant's cervical spine also revealed nontenderness and pain in the left paracervical area with lateral flexion towards the left and right. She diagnosed lumbar spinal stenosis and cervical radiculopathy.

Appellant underwent a cervical spine diagnostic scan by Dr. Amr A. Mourad, a Board-certified radiologist, who related in an August 12, 2015 report that he complained of left side pain and radiculopathy. Dr. Mourad noted a loss of normal cervical lordosis, degenerative changes with marginal osteophyte formation and sclerosis, and narrowing of the neural foramina at C3-4, C4-5, and C5-6 and C6-7 neural foramina.

In a September 15, 2015 progress note, Dr. Joon Lee, a Board-certified orthopedic surgeon, indicated that appellant was scheduled for lumbar surgery on September 25, 2015. He explained that appellant recently had a fall and complained of worsening left-sided arm pain, weakness, and clumsiness. Dr. Lee related that, upon physical examination, he observed difficulty with range of motion secondary to neck pain. He also reported positive Spurling's sign toward the left and positive Hoffman's sign on both sides. Dr. Lee indicated that a cervical MRI scan showed severe spinal stenosis with myelomalacia at C4-5, C5-6, and C6-7 levels with cord compression. He recommended that appellant undergo cervical surgery before the scheduled lumbar surgery.

Appellant underwent a cervical spine MRI scan by Dr. Taik-Kun Kim, a Board-certified neuroradiologist, who noted in a September 2, 2015 report that appellant had severe multilevel degenerative changes and congenitally short pedicles resulting in chronic compressive myelopathy at C3-4, C4-5, and C5-6.

On September 16, 2015 appellant underwent cervical laminectomy, facetectomy, and foraminotomy with decompression of the spinal cord.

On October 28, 2015 appellant filed a claim for wage-loss compensation (Form CA-7) for the period August 9 to 22, 2015.

By letter dated October 28, 2015, OWCP informed appellant that his claim was initially approved as a minor injury, but it was being reopened because he requested wage-loss compensation. It advised him that the evidence submitted was insufficient to establish his claim. OWCP requested that appellant respond to an attached development questionnaire in order to substantiate that the June 22, 2015 incident occurred as alleged and provide additional medical evidence to establish a diagnosed condition causally related to the alleged June 22, 2015 incident. Appellant was afforded 30 days to submit additional evidence.

Appellant continued to file various Form CA-7 claims for wage-loss compensation for the period August 23 to November 28, 2015.

On November 13, 2015 OWCP received appellant's completed development questionnaire. Appellant explained that he was on break and going from the ground floor to the first floor. He reported that when he stepped off the elevator his left foot slipped on some split coffee on the floor and he fell backwards. Appellant related that he immediately felt pain in his shoulder and back and was taken to employee health and the emergency room. He indicated that he did not have any similar neck or back disabilities or symptoms before this injury.

In a decision dated December 1, 2015, OWCP denied appellant's claim. It accepted that the June 22, 2015 employment incident occurred as alleged and that he was diagnosed with a lumbar condition, but it denied his claim because the medical evidence of record failed to establish causal relationship between the diagnosed medical condition and the accepted June 22, 2015 employment incident.

Appellant resubmitted the July 13, 2015 emergency room records and discharge instructions and Dr. Lee's September 15, 2015 progress note.

On January 13, 2016 appellant requested a telephonic hearing and a review of the written record by a representative of OWCP's Branch of Hearings and Review. By decision dated February 8, 2016, an OWCP hearing representative denied his request for a telephone hearing and a review of the written record because his request was not made within 30 days of OWCP's December 1, 2015 decision. She exercised her discretion and determined that the issue in appellant's case could equally well be addressed by requesting reconsideration.

On November 17, 2016 appellant, through counsel, requested reconsideration. He related that he was submitting a November 8, 2016 report by Dr. Lee, which was not previously considered.

In a November 8, 2016 report, Dr. Lee indicated that appellant was seen at his clinic in September 2015 for symptomatic lumbar stenosis and scheduled for lumbar surgery. He related that appellant initially had no complaints of cervical symptoms, but was again examined on September 15, 2015 after sustaining a fall at work. Dr. Lee reported that appellant complained of left arm pain, weakness, clumsiness, and worsening balance issues. He related that a cervical spine MRI scan showed severe spinal stenosis with myelomalacia at C4-5, C5-6, and C6-7 levels. Dr. Lee provided his examination findings. He opined that appellant had "preexisting asymptomatic cervical stenosis that was exacerbated by the fall after which [appellant]

developed symptomatic myelopathy and myelomalacia changes on his MRI scan." Dr. Lee noted that appellant underwent cervical surgery on September 16, 2015.

By decision dated February 13, 2017, OWCP denied modification of its December 1, 2015 denial decision. It found that the medical evidence of record did not contain a well-rationalized medical opinion from a physician explaining how appellant's medical condition resulted from the June 22, 2015 employment incident.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative, and substantial evidence[4] including that he or she sustained an injury in the performance of duty and that any specific condition or disability from work for which he or she claims compensation is causally related to that employment injury.[5]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether fact of injury has been established.[6] There are two components involved in establishing the fact of injury. First, the employee must submit sufficient evidence to establish that he actually experienced the employment incident at the time, place, and in the manner alleged.[7] Second, the employee must submit evidence, generally only in the form of probative medical evidence, to establish that the employment incident caused a personal injury.[8] An employee may establish that the employment incident occurred as alleged, but fail to show that his or her disability or condition relates to the employment incident.[9]

Whether an employee sustained an injury in the performance of duty requires the submission of rationalized medical opinion evidence.[10] The opinion of the physician must be based on a complete factual and medical background of the employee, 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.[11] The weight of the medical evidence is determined by its reliability, its probative

[3] *Id*.

[4] *J.P*., 59 ECAB 178 (2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

[5] *G.T*., 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[6] *S.P.*, 59 ECAB 184 (2007); *Alvin V. Gadd*, 57 ECAB 172 (2005).

[7] *Bonnie A. Contreras*, 57 ECAB 364 (2006); *Edward C. Lawrence*, 19 ECAB 442 (1968).

[8] *David Apgar*, 57 ECAB 137 (2005); *John J. Carlone*, 41 ECAB 354 (1989).

[9] *T.H.*, 59 ECAB 388 (2008); *see also Roma A. Mortenson-Kindschi*, 57 ECAB 418 (2006).

[10] *See J.Z.*, 58 ECAB 529 (2007); *Paul E. Thams*, 56 ECAB 503 (2005).

[11] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 465 (2005).

value, its convincing quality, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[12]

ANALYSIS

Appellant alleged that on June 22, 2015 he strained his lower back when he slipped on spilt coffee and fell down at work. OWCP accepted that the June 22, 2015 incident occurred as alleged and that he was diagnosed with a lumbar condition. However, it denied appellant's claim finding insufficient medical evidence to establish that his diagnosed lumbar condition was causally related to the accepted incident.

The Board finds that appellant failed to meet his burden of proof to establish an injury on June 22, 2015 causally related to the accepted incident.

Dr. Kievlan initially treated appellant in the emergency room. He related in a June 22, 2015 critical care note that appellant slipped and fell down while getting out of the main elevators at work. Dr. Kievlan reported that appellant had a history of lumbar spinal stenosis and spondylolisthesis. He provided physical examination findings and diagnosed fall and left lower extremity weakness/numbness, likely exacerbation of chronic spinal stenosis/spondylolisthesis. Dr. Kievlan, however, did not provide an opinion or explain whether the described June 22, 2015 slip and fall incident at work caused or contributed to appellant's medical condition. 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.[13] Likewise, Dr. Sundaram's June 22, 2015 hospital record also fails to establish appellant's claim as he did not provide any opinion on the cause of appellant's low back symptoms. These reports, therefore, are insufficient to establish appellant's claim.[14]

Appellant was also treated by Dr. Suski in the emergency room on July 13, 2015. Dr. Suski noted a history of appellant's back pain and accurately described the June 22, 2015 employment incident. He provided physical examination findings and diagnosed chronic lumbar pain. Although Dr. Suski described the June 22, 2015 incident and provided a medical diagnosis, he did not explain how the June 22, 2015 slip and fall accident at work caused or contributed to appellant's medical condition. A physician must provide a narrative description of the identified employment incident and a reasoned opinion on whether the employment incident described caused or contributed to appellant's diagnosed medical condition.[15]

Likewise, Dr. Pasunur's August 12, 2015 progress note also fails to establish appellant's claim as she accurately described the June 22, 2015 employment incident and noted diagnoses of lumbar spinal stenosis and cervical radiculopathy, but did not opine as to the causal relationship

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

[13] *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).

[14] *Id*.

[15] *John W. Montoya*, 54 ECAB 306 (2003).

of the incident and diagnosis.[16] For these reasons, this medical report also fails to establish his traumatic injury claim.

Appellant submitted various medical reports by Dr. Lee. In a September 15, 2015 progress note, Dr. Lee related that appellant recently had a fall at work and complained of worsening left-sided arm pain, weakness, and clumsiness. He noted that appellant had a history of spinal stenosis and was scheduled for lumbar surgery on September 25, 2015. Upon physical examination of appellant's cervical spine, Dr. Lee reported difficulty with range of motion secondary to neck pain. Spurling's sign was positive toward the left and Hoffman's sign was positive on both sides. In a November 8, 2016 report, Dr. Lee opined that appellant had "preexisting asymptomatic cervical stenosis that was exacerbated by the fall after which [appellant] developed symptomatic myelopathy and myelomalacia changes on his MRI scan." The Board notes that, although Dr. Lee provided an affirmative opinion which supported causal relationship, he did not offer any rationalized medical explanation to support his opinion. Medical evidence that states a conclusion, but does not offer any rationalized medical explanation regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[17] Rationalized medical opinion evidence is especially needed in this case since appellant has a history of a preexisting lumbar condition. Although Dr. Lee emphasized that appellant was not symptomatic before the fall, he failed to provide a reasoned opinion on how the June 22, 2015 employment incident contributed to or exacerbated appellant's lumbar condition.[18] For these reasons, his reports fail to establish appellant's claim.

The diagnostic reports dated June 22, 2015 by Drs. Lapidus, Rhoads, and Gupta are also insufficient to establish appellant's traumatic injury claim. Diagnostic testing is of limited probative value as it fails to provide a physician's opinion on the causal relationship between appellant's work incident and his conditions.[19]

While the physicians noted degenerative changes of the sacroiliac and bilateral hip joints, decreased disc spaces in the lumbar spine, and degenerative disc disease of the lumbar spine, none of the physicians provided any opinion on the cause of appellant's medical conditions. As none of these physicians offered an opinion on whether his medical conditions were causally related to his employment, these reports are insufficient to establish his claim.[20] Similarly, Dr. Mourad's August 12, 2015 cervical spine radiology report and Dr. Kim's September 2, 2015 cervical spine MRI scan report also fail to establish appellant's claim as none of the physician's offered an opinion on whether appellant's cervical spine condition was causally related to the June 22, 2015 employment incident.[21]

[16] *Id*.

[17] *J.F.*, and *A.D.*, *supra* note 13.

[18] *Supra* note 15.

[19] *G.C.*, Docket No. 17-0675 (issued June 15, 2017).

[20] *R.E.*, Docket No. 10-0679 (issued November 16, 2010); *K.W.*, 59 ECAB 271 (2007).

[21] *Supra* note 19.

In order to obtain benefits under FECA an employee has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative, and substantial evidence.[22] Because appellant has failed to provide such evidence demonstrating that his lumbar condition was causally related to the June 22, 2015 incident, he has failed to meet his burden of proof to establish his claim.

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 has not met his burden of proof to establish an injury causally related to the accepted June 22, 2015 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the February 13, 2017 merit decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 2, 2017
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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

[22] *Supra* note 5.