United States Department of Labor
Employees' Compensation Appeals Board

A.S., Appellant	)	
and	)	
DEPARTMENT OF THE ARMY, DEFENSE LANGUAGE INSTITUTE FOREIGN LANGUAGE CENTER, Presidio of Monterey, CA, Employer	)	**Docket No. 17-0923** **Issued: August 15, 2018**

Appearances:
Max Gest, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 22, 2017 appellant, through counsel, filed a timely appeal from a February 14, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP).[2] Pursuant to the

[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] By order dated September 5, 2017, the Board dismissed the appeal because appellant had not signed the application for review (AB-1) and there was no evidence that he had authorized counsel's representation. *Order Dismissing Appeal*, Docket No. 17-0923 (issued September 5, 2017). Counsel subsequently petitioned the Board for reconsideration and submitted a September 21, 2017 document signed by appellant authorizing his representation before the Board. On May 1, 2018 the Board issued an order vacating its September 5, 2017 order and reinstating the appeal. *Order Vacating Prior Board Order and Reinstating Appeal*, Docket No. 17-0923 (issued May 1, 2018).

Federal Employees' Compensation Act[3] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of this case.

ISSUE

The issue is whether appellant has met his burden of proof to establish that his diagnosed lumbar conditions were causally related to the accepted July 28, 2016 employment incident.

FACTUAL HISTORY

On August 4, 2016 appellant, then a 73-year-old assistant professor, filed a traumatic injury claim (Form CA-1) alleging that, while exiting the auditorium at the conclusion of a work meeting on July 28, 2016, he tripped and fell over a chair that was in the aisle. He explained that his right foot got stuck causing him to fall on the chair, and as he fell to the ground, he twisted and landed on his left side. Appellant also explained that two months prior to the fall he had undergone back surgery, which included lumbar fusion and decompression. The evening after the July 28, 2016 fall, appellant's previous pain returned with intensity. He stopped work on July 29, 2016. Appellant indicated that he had been referred back to his previous surgeon, who planned to do surgery.

A July 29, 2016 clinical summary indicated that appellant was treated for low back pain. He received medication for pain and inflammation, a muscle relaxant, and was referred for lumbar x-rays. The July 29, 2016 clinical summary also indicated that appellant was referred to a back surgeon. It was noted that he had previously undergone lumbar fusion in May 2016 and was status post "fall and new back pain."

On August 1, 2016 Dr. Pejman E. Shirazy, a Board-certified physiatrist, advised that appellant was on medical leave from August 1 through September 1, 2016.

In an August 19, 2016 claim development letter, OWCP advised appellant that the evidence received to date was insufficient to support his claim. It specifically noted that the July 29 and August 1, 2016 medical documents did not "diagnose a medical condition." OWCP afforded appellant 30 days to submit a narrative medical report from a physician that included, *inter alia*, a medical diagnosis and an explanation as to how the reported work incident either caused or aggravated the claimed injury.

By decision dated September 23, 2016, OWCP accepted that the July 28, 2016 employment incident occurred as alleged, but denied the claim because appellant failed to establish the medical component of fact of injury. It explained that appellant had not submitted any evidence containing a medical diagnosis in connection with the employment incident. Appellant did not respond to OWCP's August 19, 2016 claim development letter within the time he had been afforded.

[3] 5 U.S.C. § 8101 *et seq.*

On January 10, 2017 counsel requested reconsideration. He submitted several witness statements regarding the accepted July 28, 2016 employment incident, as well as additional medical evidence.

On July 29, 2016 Dr. Neeraj Satyanarayana, an internist, examined appellant for complaints of low back pain. Appellant reported an acute fall the day before, noting that he tripped over a chair and fell to the ground landing on his left side with his back twisted. He experienced back pain and decreased range of motion similar to that experienced prior to his lumbar fusion in May 2016. Dr. Satyanarayana noted findings of slowed gait, limited range of motion of the back, and tenderness over the lumbar spine. He diagnosed low back pain. Dr. Satyanarayana performed lumbar injections and referred appellant to a lumbar surgeon.

On October 3, 2016 Dr. Greg S. Khounganian, a Board-certified orthopedic surgeon, examined appellant for complaints of back pain. He previously treated appellant in May 2016. Dr. Khounganian noted that appellant returned on that date for follow-up after a July 28, 2016 injury at work when he fell over a chair. Since the injury, appellant reported continued low back pain with radiating symptoms down the lower extremity. Dr. Khounganian reported that appellant was currently using a cane and wearing a back brace due to his pain. He reviewed a May 19, 2016 lumbar x-ray, which demonstrated well-placed instrumentation at L4-5. Dr. Khounganian also reviewed an October 3, 2016 lumbar x-ray, which revealed the implants at L4-5 were in good placement, with no evidence of hardware failure or evidence of hardware loosening. He also noted that there was no evidence of fractures on appellant's latest lumbar x-rays. Dr. Khounganian diagnosed lumbosacral spondylosis without myelopathy/radiculopathy, lumbosacral intervertebral disc displacement, lumbar intervertebral disc degeneration, and sciatica. He referred appellant for additional diagnostic studies. Dr. Khounganian explained that given appellant's prior lumbar surgery he needed to be extra cautious regarding reherniations or injury to the actual implants at L4-5.

An October 4, 2016 lumbar magnetic resonance imaging (MRI) scan revealed mild retrolisthesis of L1 with left disc extrusion and disc bulging, mild retrolisthesis of L2 with disc bulging, mild retrolisthesis of L3 with disc bulging and mild posterior osteophytic spurring, and L4-5 status post anterior and posterior surgical fusion. An October 5, 2016 lumbar computerized tomography (CT) scan revealed status post anterior and posterior surgical fusion at L4-5 without any bony bridging and status post resection of the left L1 laminectomy.

In an October 10, 2016 follow-up report, Dr. Khounganian reviewed the recent lumbar CT and MRI scans. He explained that appellant was status post L1-2 discectomy on the left side, as well as L4-5 posterior lumbar instrumented fusion, and prior to a July 28, 2016 fall at work, appellant had been doing very well postoperatively. Based on the recent diagnostic studies, everything appeared to be well placed with no failure of instrumentation. Dr. Khounganian also noted that there appeared to be a left-sided disc bulge at L1-2. He noted that it was smaller than prior to surgery, but may represent a reherniation from his recent injury. Dr. Khounganian further noted that appellant's symptoms of left posterior thigh pain and sciatica may be secondary to his recent injury causing reexacerbation and inflammation of nerve roots radiating down the left leg. He explained that the pattern of symptoms may be referred from L4-5 and L5-S1 on the left side. Dr. Khounganian further explained that postoperative scar tissue may inflame from an injury like appellant had on July 28, 2016, which can cause an exacerbation of his current symptoms. He also noted that currently appellant did not have significant symptoms related to the L1-2 reherniation

on the left side. However, it may cause recurrent symptoms in the future. Dr. Khounganian recommended that appellant return to his pain management specialist for selective nerve root blocks at L4-5 and L5-S1 levels.

Dr. Shirazy also examined appellant on October 10, 2016 for complaints of severe pain in his lumbar spine and left leg. Appellant reported difficulty with standing and walking, numbness, tingling, and paresthesia in his left lower extremity. Dr. Shirazy noted appellant's history was significant for anterior and posterior fusion at L4-5 in May 2016. Postoperatively appellant was doing quite well without using pain medication and with significant functional improvement. Dr. Shirazy noted that since the industrial fall of July 28, 2016, appellant experienced increased pain in his lumbar spine and left lower extremity and was using a cane for mobility. He noted that an October 4, 2016 MRI scan of the lumbar spine revealed an L1-2 disc extrusion, which appeared to correlate with appellant's symptoms of pain and radiation to the left lower extremity. Dr. Shirazy opined that this injury appeared to be new in nature and correlated to the industrial injury sustained on July 28, 2016. He noted findings of tenderness to palpation of the lumbar spine, paravertebral region, gluteus region, and piriformis regions. Dr. Shirazy diagnosed disc herniation without myelopathy, lumbago, lumbar lordosis, lumbar enthesopathy, lumbar ligament laxity, lumbar myalgia, lumbar myospasm, lumbar neuritis/radiculitis, lumbar nerve root injury, sciatic neuritis, sensation disturbance of the limb, lumbar sprain/strain, and lower extremity weakness. He recommended lumbar epidural injections and opined that appellant would eventually require surgical fusion at L1-2.

In a December 6, 2016 report, Dr. Jacob E. Tauber, a Board-certified orthopedic surgeon, noted that on July 28, 2016 appellant was walking in a crowded aisle when his right foot got caught in a chair causing him to jerk his body and fall to the ground landing on his left side. He experienced pain in his left hand and lower back radiating into his left leg. Appellant underwent physical therapy and two lumbar injections, which provided temporary relief and he remained off work. His history was significant for surgery to his lower back in May 2016. Dr. Tauber noted findings of pain on lumbar motion, positive straight raise leg testing on the left, decreased sensation to pinprick in the left lower extremity, depressed Achilles reflex, weakness, and atrophy. He noted that appellant underwent an L4-5 decompression and fusion and an L1-2 decompression with discectomy. Dr. Tauber diagnosed history of L4-5 fusion and L1-2 decompression with subsequent work injury resulting in reherniation at L1-2, aggravation of stenosis at L3-4, and aggravation of postoperative L4-5 fusion. He noted that appellant was progressing well postoperatively and had returned to work and was carrying out his duties until he had the fall at work. Dr. Tauber opined that appellant appeared to have a reherniation at L1-2 and an aggravation of stenosis at levels proximal to the fusion. He noted that appellant had significant objective findings of pathology and was unable to work.

By decision dated February 14, 2017, OWCP found that appellant had established that on July 28, 2016 he "tripped and fell" while in the performance of duty. It also noted that, since the prior denial, "a myriad of medical conditions" had been diagnosed. Thus, appellant established both components of fact of injury. However, OWCP found that the case remained denied because causal relationship had not been established. Accordingly, it modified its prior decision to reflect that appellant established fact of injury, but the claim remained denied because the medical evidence of record was insufficient to establish causal relationship.

LEGAL PRECEDENT

A claimant seeking benefits under FECA[4] 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, including that an injury was sustained in the performance of duty as alleged, and that any specific condition or disability claimed is causally related to the employment injury.[5]

To determine if an employee sustained a traumatic injury in the performance of duty, OWCP begins with an analysis of whether fact of injury has been established. Generally, fact of injury consists of two components that must be considered in conjunction with one another. The first component is whether the employee actually experienced the employment incident that allegedly occurred.[6] The second component is whether the employment incident caused a personal injury.[7] An employee may establish that an injury occurred in the performance of duty as alleged, but fail to establish that the disability or specific condition for which compensation is being claimed is causally related to the injury.[8]

Causal relationship is a medical question that generally requires rationalized medical opinion evidence to resolve the issue.[9] A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factor(s) must be based on a complete factual and medical background.[10] Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty, and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factor(s).[11]

In any case where a preexisting condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation, acceleration or precipitation, the physician must provide a rationalized medical opinion that differentiates between the effects of the work-related injury or disease and the preexisting condition.[12]

ANALYSIS

OWCP accepted that on July 28, 2016 appellant "tripped and fell" while in the performance of duty. It also noted that "a myriad of medical conditions" had been diagnosed, thus satisfying

[4] *See supra* note 2.

[5] 20 C.F.R. § 10.115(e), (f); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996).

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

[7] *John J. Carlone*, 41 ECAB 354 (1989).

[8] *Shirley A. Temple*, 48 ECAB 404, 407 (1997).

[9] *Robert G. Morris*, 48 ECAB 238 (1996).

[10] *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[11] *Id.*

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013).

both components of fact of injury. However, OWCP denied appellant's traumatic injury claim because the medical evidence was insufficient to establish that his diagnosed lumbar conditions were causally related to the accepted July 28, 2016 employment incident. On appeal counsel argued that appellant fully recovered from his May 2016 lumbar surgery, and that the reports of Dr. Shirazy and Dr. Tauber establish that the July 28, 2016 employment incident caused a new disc herniation (L1-2) and also aggravated appellant's lumbar stenosis (L3-4). The Board finds that appellant did not meet his burden of proof to establish causal relationship.

Appellant's October 2016 lumbar MRI and CT scans are of limited probative value as they fail to provide an opinion on the causal relationship between appellant's work incident and his diagnosed low back conditions.[13] As such, this evidence is insufficient to meet his burden of proof.

Appellant was treated by Dr. Khounganian on October 3 and 10, 2016, for follow-up after a work injury occurred on July 28, 2016 when he fell over a chair. Dr. Khounganian reported low back pain with radiating symptoms since the injury. He diagnosed spondylosis without myelopathy/radiculopathy in the lumbosacral region, disc displacement in the lumbosacral region, disc degeneration in the lumbar region, and sciatica. Dr. Khounganian indicated that appellant was doing well status post L1 discectomy and L4-5 lumbar instrumented fusion, but on July 28, 2016 he fell over a chair at work and has experienced significant pain to the lower back radiating to the lower extremities bilaterally. Although Dr. Khounganian provides some support for causal relationship, the medical report is of limited probative value because it contains a conclusion regarding causal relationship which is unsupported by medical rationale.[14] He did not explain the process by which the accepted employment incident would have caused or aggravated a diagnosed medical condition.

Similarly, on October 10, 2016, Dr. Khounganian noted that the CT and MRI scan demonstrated an L1-2 left-sided disc bulge which "may" represent a reherniation from appellant's recent injury and his symptoms of left posterior thigh pain and sciatica "may be" secondary to his recent injury causing reexacerbation and inflammation of nerve roots radiating down the left leg. He indicated that scar tissue postoperatively "may" inflame from an injury like appellant had on July 28, 2016 that could cause and exacerbation of his current symptoms. Dr. Khounganian diagnosed spondylosis without myelopathy/radiculopathy in the lumbosacral region, disc displacement in the lumbosacral region, disc degeneration in the lumbar region, and sciatica. The Board notes that this report provides some support for causal relationship, but is insufficient to establish the claimed conditions are causally related to appellant's employment duties. Dr. Khounganian's report, at best, provides speculative support for causal relationship as he noted that CT and MRI scan findings demonstrated L1-2 left-sided disc bulge which "may" represent a reherniation from his recent injury and scar tissue postoperatively "may" inflame from an injury like appellant had on July 28, 2016.[15] In addition, Dr. Khounganian provided no medical

[13] *See A.D.*, 58 ECAB 149 (2006); Docket No. 06-1183 (issued November 14, 2006) (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] *See T.M.*, Docket No. 08-0975 (issued February 6, 2009) (a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale).

[15] *See D.D.*, 57 ECAB 734 (2006) (medical opinions that are speculative or equivocal in character are of diminished

reasoning explaining how the particular workplace incident caused or aggravated the diagnosed conditions.

Appellant submitted an October 10, 2016 report from Dr. Shirazy who treated him for severe pain in his lumbar spine and left leg. Dr. Shirazy noted appellant's history was significant for anterior and posterior fusion at L4-5 in May 2016 and indicated that he was doing well postoperatively. Dr. Shirazy noted that since the industrial fall of July 28, 2016 appellant experienced increased pain in his lumbar spine and left lower extremity and was using a cane for mobility. He noted that an October 4, 2016 MRI scan of the lumbar spine revealed an L1-2 disc extrusion which correlated with appellant's symptoms of pain and radiation to the left lower extremity. Dr. Shirazy diagnosed disc herniation without myelopathy, lumbago, lumbar lordosis, lumbar enthesopathy, lumbar ligament laxity, lumbar myalgia, lumbar myospasm, lumbar neuritis/radiculitis, sciatic neuritis, sensation disturbance of the limb, lumbar sprain/strain, and lower extremity weakness. He opined that this injury appeared to be new in nature and correlated to the industrial injury sustained on July 28, 2016. The Board finds that, although Dr. Shirazy supported causal relationship, he did not provide medical rationale explaining the basis of his conclusory opinion that appellant's diagnosed lumbar conditions were due to the accepted work incident of July 28, 2016.[16] Dr. Shirazy did not explain the process by which tripping and falling caused or aggravated the diagnosed conditions and why appellant's condition was not related to his recent lumbar fusion and compression surgery performed in May 2016.[17] The Board notes that medical rationale on causal relationship is particularly important as appellant has a preexisting lumbar condition.[18] Therefore, this report is insufficient to meet appellant's burden of proof.

Appellant submitted a December 6, 2016 report from Dr. Tauber. He reported that on July 28, 2016 he was walking in a crowded aisle when his right foot got caught in a chair causing him to jerk his body and fall to the ground landing on his left side. Appellant experienced pain in his left hand and lower back radiating into his left leg. Dr. Tauber diagnosed history of L4-5 fusion and L1-2 decompression with subsequent work injury resulting in reherniation at L1-2, aggravation of stenosis at L3-4, and postoperative L4-5 fusion. He noted that appellant was progressing well postoperatively until he had a fall at work. Dr. Tauber opined that appellant appeared to have a reherniation at L1-2 and aggravation of stenosis at levels proximal to the fusion. The Board finds that, although Dr. Tauber supported causal relationship, he did not provide medical rationale explaining the basis of his conclusory opinion that appellant's reherniation at L1-2 and aggravation of stenosis at levels proximal to the fusion was due to the accepted work incident of July 28, 2016.[19] Dr. Tauber did not explain the process by which tripping and falling

probative value).

[16] *See supra* note 14.

[17] *Id.*

[18] *J.M.*, 58 ECAB 478 (2007) (where the Board found that appellant did not meet his burden of proof in establishing a work-related right wrist condition where his physician provided only conclusory support for causal relationship and did not identify any of the job duties appellant performed or explain how his work duties caused or contributed to his condition. Medical rationale was particularly necessary given that appellant injured his wrist while lifting luggage in private employment. As the opinion of appellant's physician regarding causal relationship was conclusory and unexplained, it was insufficient to meet appellant's burden of proof).

[19] *See supra* note 14.

would cause or aggravate the diagnosed conditions and why appellant's condition was not related to his recent lumbar fusion and compression surgery performed in May 2016.[20] The Board notes that medical rationale on causal relationship is particularly important as appellant has a preexisting lumbar condition.[21] Therefore, this report is insufficient to meet appellant's burden of proof.

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 that his diagnosed lumbar conditions are causally related to the accepted July 28, 2016 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the February 14, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 15, 2018
Washington, DC

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

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

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

[20] *Id.*

[21] *See J.M., supra* note 18.