United States Department of Labor
Employees' Compensation Appeals Board

S.N., Appellant	)	
and	)	**Docket No. 19-1050**
	)	**Issued: July 31, 2020**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRATION, Fresno, CA, Employer	)	

Appearances:
Daniel M. Goodkin, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

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

JURISDICTION

On April 10, 2019 appellant, through counsel, filed a timely appeal from an October 12, 2018 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 has established that the acceptance of her claim should be expanded to include additional conditions causally related to her accepted April 28, 2002 employment injury.

FACTUAL HISTORY

On April 29, 2002 appellant, then a 55-year-old nurse, filed a traumatic injury claim (Form CA-1) alleging that on April 28, 2002 she sustained injuries to her face and chest when struck by an airbed while she was in the performance of duty. She stopped work on May 12, 2002. Appellant returned to part-time modified duty on October 5, 2002 and to full-time modified work on August 18, 2003. OWCP accepted the claim for cervical and lumbar strain. It subsequently expanded acceptance of the claim to include the additional conditions of permanent aggravation of lumbar sprain, recurrent urinary incontinence,[3] thoracic sprain resolved January 20, 2017, and depression not otherwise specified. OWCP paid appellant supplemental wage-loss compensation from June 28, 2002 to August 15, 2003 and September 22 to October 3, 2008. She stopped work on November 15, 2010.

A magnetic resonance imaging (MRI) scan of the lumbar spine dated September 8, 2014 revealed a left hemilaminectomy at L5-S1, a left posterolateral disc protrusion at L5-S1 leading to S1 nerve root, and a mild broad-based disc bulge at L3-4. A cervical spine MRI scan demonstrated degenerative changes, mild to moderate central spinal stenosis at C4-5 and C5-6, mild stenosis at C6-7, moderate narrowing at C4-5 and C5-6, and mild narrowing at C4-5 and C5-6.

In a report dated June 22, 2015, Dr. Harwinder Singh, a Board-certified physiatrist, reviewed appellant's history of employment injury on April 28, 2002 adjusting a patient's bed. He discussed her complaints of back pain radiating into the left lower extremity, cervicoscapular pain with headaches, and recurrent urinary tract infections. Dr. Singh reviewed the results of appellant's cervical and lumbar MRI scans and September 12, 2002 electrodiagnostic testing showing S1 radiculopathy. He diagnosed cervical degenerative disc disease and disc protrusion causing left radiculopathy at C5-6, a symptomatic L5-S1 disc herniation causing bilateral S1 radiculitis worse on the left, complex urological surgery with recurrent urinary tract infection and urinary stones, chronic reactive depression, chronic fatigue, and psychosocial stressors. Dr. Singh asserted that treatment for appellant's back condition should be provided by OWCP as it was employment related.

On January 26, 2016 Dr. Singh referred appellant for a transforaminal epidural steroid injection.

[3] By decision dated March 22, 2012, OWCP terminated appellant's medical and wage-loss benefits for the accepted condition of urinary incontinence. On June 17, 2013 OWCP denied modification of this decision. On December 10, 2013 appellant appealed the claim to the Board. By order dated August 1, 2014, the Board set aside the June 17, 2013 decision and remanded the case for further proceedings finding that OWCP failed to properly consider all evidence submitted prior to issuance of the June 17, 2013 decision. *Order Remanding Case*, Docket No. 14-0352 (issued August 1, 2014). By decision dated December 2, 2014, OWCP vacated the decision dated March 22, 2012 terminating medical and wage-loss benefits for the accepted condition of urinary incontinence.

In a development letter dated January 27, 2016, OWCP noted that it had accepted appellant's claim for lumbar sprain, neck sprain, and urinary incontinence. It informed her that the evidence of record was insufficient to authorize a lumbosacral epidural injection as it did not appear to be necessary for any of her accepted conditions. OWCP advised appellant to submit a detailed report from her attending physician addressing whether she sustained additional employment-related conditions.

In a report dated February 22, 2016, Dr. Singh requested that appellant's claim be expanded to include an acute disc herniation leading to left S1 radiculitis. He noted that after an initial diagnosis of back pain diagnostic studies had revealed "a large posterolateral disc protrusion at L5-S1 leading to left S1 nerve root compression" with radiculopathy at S1. Dr. Singh diagnosed chronic cervical pain due to degenerative disc disease, a disc protrusion leading to left C5-6 radiculopathy, severe low back pain due to symptomatic L5-S1 disc herniation leading to bilateral S1 radiculitis, complex urological surgery with recurrent urinary tract infections (UTI), chronic depression, and chronic fatigue. He recommended diagnostic therapeutic left S1 joint steroid injections.

On April 12, 2016 appellant, through counsel, requested that her claim be expanded to include the additional condition of acute disc herniation leading to left S1 radiculitis and that OWCP authorize the lumbar spinal injection with Dr. Singh.

On May 12, 2016 OWCP reviewed Dr. Singh's February 22, 2016 report and found it insufficient to establish that appellant's claim should be expanded to include an acute disc herniation leading to left S1 radiculitis. It requested that she provide a comprehensive medical report from her treating physician supported by a medical explanation as to the relationship between acute disc herniation leading to left S1 radiculitis and the April 8, 2002 employment injury. OWCP afforded appellant 30 days to submit the requested information.

On July 12, 2016 Dr. Singh evaluated appellant for severe low back pain with radiation into the left lower extremity, difficulty walking, chronic cervical spine pain with associated suboccipital headaches, chronic fatigue related to recurrent UTI, psychosocial stressors, and severe depression related to pain. He provided examination findings and diagnosed severe low back pain due to symptomatic L5-S1 disc herniation leading to bilateral S1 radiculitis, cervicoscapular pain due to degenerative disc disease leading to left C5-6 radiculitis, complex urological surgery with recurrent UTI, chronic reactive depression, and fatigue.

By decision dated October 21, 2016, OWCP denied expansion of appellant's claim to include the additional condition of acute disc herniation leading to left S1 radiculitis. It found that she had not submitted rationalized medical evidence addressing how the April 28, 2002 injury caused or contributed to the diagnosed conditions.

Subsequently, OWCP received an October 12, 2016 from Dr. Singh, who requested that appellant's claim be expanded to include a disc herniation causing left lumbar radiculitis. Dr. Singh noted symptoms of severe low back pain, muscle spasm radiating into the left lower extremity, cervicoscapular pain, status post complex bladder procedure, chronic depression related to pain, chronic fatigue related to recurrent UTI, and psychosocial stressors. He indicated that during the time he had treated appellant she consistently had left lower extremity radiculopathy as

confirmed by EMG and nerve conduction studies. Dr. Singh again recommended an L5-S1 transforaminal epidural steroid injection.

On October 27, 2016 appellant, through counsel, requested reconsideration. Counsel requested expansion of appellant's claim to include L5-S1 radiculitis and a herniated disc at L5-S1.

On November 23, 2016 OWCP referred appellant to Dr. Aubrey A. Swartz, a Board-certified orthopedic surgeon, for a second opinion examination. It requested that he address whether she had established an acute herniation causing left S1 radiculitis and degenerative disc disease causing left radiculitis at C5-6.

In a report dated January 30, 2017, Dr. Swartz reviewed appellant's history of injury and the medical evidence of record. He advised that she had normal lumbar range of motion, full strength of the upper extremities, and a negative straight leg raise bilaterally. Dr. Swartz further found no lumbar, thoracic, or cervical spasm. He noted that appellant had a history of a prior back injury and that early reports had documented soft tissue injuries. Dr. Swartz opined, "With respect to an acute herniation leading to left S1 radiculitis and disc degenerative disease leading to left C5-6 radiculitis, this never occurred and was never demonstrated. These diagnoses were primarily carried forward from visit to visit by Dr. Singh, who never found clinical objective evidence of radiculopathy of either the cervical or lumbar spine." Dr. Swartz advised that appellant had a "basically unremarkable orthopedic examination" with some hypesthesias and collapsing weakness in the left lower extremity, which he advised were not clinically valid responses. He diagnosed cervical, thoracic, and lumbar strains, all of which had resolved by February 26, 2003. Dr. Swartz further opined that appellant's gynecologic, pelvic, and urinary problems were not caused or aggravated by the employment injury. He noted that she had undergone prior surgery to the lumbar spine and had degenerative changes of the lumbar spine at L4-5 and L5-S1 unrelated to her employment injury by either direct causation or aggravation. Dr. Swartz advised that appellant could resume work full-time limited duty with restrictions related to age rather than the employment injury.

In reports dated January 11 and February 9, 2017, Dr. Singh diagnosed severe low back pain due to a symptomatic L5-S1 disc herniation leading to an L5-S1 disc herniation, left sacroiliac dysfunction, cervicoscapular pain due to symptomatic disc herniation leading to C6 radiculopathy, recurrent UTI, chronic reactive depression, and chronic fatigue.

OWCP referred appellant to Dr. Alberto G. Lopez, a Board-certified psychiatrist, for a second opinion examination.

In a report dated February 1, 2017, Dr. Lopez diagnosed depression not otherwise specified causally related to appellant's employment-related chronic back and neck pain. He advised that she also experienced fatigue due to her depression.

In a supplemental report dated April 22, 2017, Dr. Lopez advised that appellant's chronic pain resulted from the accepted conditions of sprain and incontinence, and was thus causally related to her April 28, 2002 employment injury.

By decision dated April 28, 2017, OWCP vacated its October 21, 2016 decision. It expanded acceptance of appellant's claim to include the additional conditions of resolved thoracic

sprain and depression not otherwise specified. OWCP denied expanding her claim to include an acute herniation causing left S1 radiculitis, and cervicoscapular pain due to degenerative disc disease leading to left radiculitis at C5-6.

A nerve conduction velocity (NCV) study performed by Dr. Singh on July 7, 2017 showed acute right S1 radiculopathy, chronic left S1 radiculopathy, and sensorimotor peripheral polyneuropathy.

On July 10, 2017 Dr. Singh discussed appellant's history of an April 28, 2002 employment injury and noted that he had treated her since August 28, 2002 for low back pain with left lower extremity tingling and weakness. He advised that more recently she also had experienced right lower extremity radiculopathy. Dr. Singh noted that appellant had complex urological conditions that had taken priority over her other complaints during the last seven or eight years. He discussed her history of a December 1997 left hemilaminectomy at L5-S1, noting that she resumed work without restrictions after the injury. Dr. Singh discussed the result of the July 7, 2017 NCV which demonstrated radiculopathy bilaterally and a March 14, 2016 MRI scan showing a large left L5-S1 disc protrusion with compression of an existing nerve root. He advised that within five months of appellant's injury he had diagnosed radiculitis as evinced by electrodiagnostic testing and discussed his objective findings on examination of restricted movement of the lumbar spine. Dr. Singh diagnosed as employment related a herniated lumbar disc, a cervical herniated disc, lumbar radiculitis, left cervical radiculitis, urinary incontinence, and reactive depression. He noted that appellant had worked without restrictions prior to her April 2002 employment injury and that the injury was significant enough to disrupt her implanted bladder mesh necessitating multiple surgical repairs. Dr. Singh again requested that OWCP expand her claim to include the additional conditions of low back pain and an acute disc herniation causing radiculitis at S1.

On August 15, 2017 appellant, through counsel, requested reconsideration. He contended that she had sustained herniated discs and lumbar and cervical radiculitis causally related to her April 28, 2002 employment injury. Counsel asserted that Dr. Swartz was biased against claimants and based his opinion on only one evaluation.

By decision dated August 30, 2017, OWCP denied modification of its April 29, 2017 decision.

On October 9, 2017 Dr. Singh again advised that electrodiagnostic testing performed within five months of appellant's injury in 2002 had revealed left lumbar radiculitis due to a symptomatic disc herniation at L5-S1. He opined that Dr. Swartz had ignored examination findings that demonstrated clinic signs of left lumbar radiculopathy including a positive straight leg test, sensory loss, weakness in the left ankle, and EMG findings which revealed active S1 radiculitis. Dr. Singh further opined that appellant's disc herniation could be considered an aggravation of a preexisting condition.

On November 7, 2017 appellant, through counsel, requested reconsideration. Counsel asserted that there was a conflict of opinion between Dr. Singh and Dr. Swartz regarding the extent of appellant's employment-related spinal injuries.

By decision dated May 17, 2018, OWCP denied modification of the decision dated August 30, 2017. It found that Dr. Singh had failed to provide medical rationale explaining how a work incident on one day caused an aggravation of the underlying conditions.

In a report dated August 15, 2018, Dr. Singh opined that appellant had sustained a disc herniation at L5-S1 resulting in left L5-S1 radiculitis causally related to the April 28, 2002 work injury.[4] He described in detail the April 28, 2002 employment incident, noting that it had occurred when she was crouched with her spine flexed. Dr. Singh found that the weight of the bed and patient put significant pressure on appellant's flexed spine and disrupted the surgical mesh she had on her bladder. He explained, "The force caused the disc at L5-S1 to compress beyond its compressive strength. This was sufficient to cause [the] disc at L5-S1 to rupture." Dr. Singh opined that he based his conclusion on appellant's description of the work injury, clinical examination, and the results of objective testing in September 2002 and 2017 showing active lumbar radiculitis. He advised that she had recovered from the left hemilaminectomy at L5-S1 performed in December 1997 such that she was working without restrictions within six months of surgery. Dr. Singh opined that if it were not for the incident on April 28, 2002 she would not have sustained a disc herniation with radiculitis. He requested that appellant's claim be expanded to include left posterior lateral disc herniation causing left L5-S1 radiculitis.

On August 27, 2018 appellant, through counsel, requested reconsideration, asserting that a conflict existed between Dr. Swartz and Dr. Singh regarding whether she had sustained permanent damage to her spine as a result of the April 28, 2002 work injury.

By decision dated October 12, 2018, OWCP denied modification of its May 17, 2018 decision.

LEGAL PRECEDENT

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]

Causal relationship is a medical issue, and the medical evidence required to establish causal relationship is rationalized medical evidence.[6] 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 claimant.[7] The weight of medical evidence is determined by its reliability, its probative value, its convincing

[4] Dr. Singh also provided a progress report dated June 5, 2018.

[5] *See T.F.*, Docket No. 17-0645 (issued August 15, 2018); *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[6] *See S.A.*, Docket No. 18-0399 (issued October 16, 2018); *Kenneth R. Love*, 50 ECAB 276 (1999).

[7] *See P.M.*, Docket No. 18-0287 (issued October 11, 2018); *John W. Montoya*, 54 ECAB 306 (2003).

quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.[8]

Section 8123(a) provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[9] The implementing regulation states that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[10]

ANALYSIS

The Board finds that the case is not in posture for decision.

The Board finds that a conflict in medical opinion exists between Dr. Singh, appellant's attending physician, and Dr. Swartz, OWCP's referral physician, regarding whether she sustained additional conditions, including a disc herniation causing left S1 radiculitis and cervical radiculitis, as a result of the accepted April 28, 2002 employment injury.

OWCP accepted that appellant sustained cervical and lumbar strain, a permanent aggravation of lumbar sprain, recurrent urinary incontinence, thoracic sprain that had resolved by January 20, 2017, and depression not otherwise specified when attempting on April 28, 2002 to put an airbed in Trendelenberg position. Initially, the Board notes that Dr. Singh specifically requested that appellant's claim be expanded to include a disc herniation at L5-S1 causing left lumbar radiculitis. In a report dated July 10, 2017, Dr. Singh additionally diagnosed as employment related a cervical herniated disc and cervical radiculitis. OWCP requested that Dr. Swartz, the second opinion physician, address whether appellant had sustained an acute herniated lumbar disc causing left S1 radiculitis or cervical degenerative disc disease causing left C5-6 radiculitis.

On February 22, 2016 Dr. Singh requested that OWCP expand acceptance of appellant's claim to include an acute disc herniation causing left S1 radiculitis. In an October 12, 2016 report, he noted that appellant had consistent symptoms of radiculopathy of the left lower extremity confirmed by electrodiagnostic testing. On July 10, 2017 Dr. Singh indicated that she had a history of a hemilaminectomy on the left at L5-S1 in 1997, following which she had resumed work without restrictions. He related that he had treated appellant beginning August 2002 and that within five months of her injury had diagnosed radiculitis. Dr. Singh diagnosed a herniated lumbar and cervical disc and lumbar and cervical radiculitis causally related to the accepted employment injury. On October 9, 2017 he opined that the employment injury had aggravated appellant's

[8] *See H.H.*, Docket No. 16-0897 (issued September 21, 2016); *James Mack*, 43 ECAB 321 (1991).

[9] 5 U.S.C. § 8123(a).

[10] 20 C.F.R. § 10.321; *see also F.V.*, Docket No. 18-0230 (issued May 8, 2020); *Shirley L. Steib*, 46 ECAB 309 (1994).

preexisting back condition. In an August 15, 2018 report, Dr. Singh indicated that when the incidence occurred on April 28, 2002, she was in a crouched position with her spine flexed and that the unexpected dropping of the bed had put pressure on her already flexed spine. He opined that this force was sufficient to cause disruption of the surgical mesh on her bladder. Dr. Singh found that the incident compressed the L5-S1 disc such that the disc ruptured. He explained that he had based his findings on appellant's description of the work injury, clinical examination, and the results of diagnostic testing. Dr. Singh opined that if it were not for the incident on April 28 2002 appellant would not have sustained a disc herniation with radiculitis.

By contrast, Dr. Swartz opined in a report dated January 30, 2017 that appellant had not sustained either a disc herniation causing S1 left radiculitis or cervical degenerative disc disease causing C5-6 radiculitis. He advised that her orthopedic examination was basically unremarkable. Dr. Swartz diagnosed resolved sprains of the cervical, thoracic, and lumbar spine. He found no clinical objective evidence of radiculopathy of either the cervical or lumbar spines and indicated that the straining injury would not have reached the level to cause any aggravation of a preexisting condition.

Both Dr. Singh and Dr. Swartz provided a description of the employment injury and both discussed the medical evidence and their physical findings. The Board, therefore, finds that a conflict in medical opinion exists regarding whether appellant developed additional conditions as a result of the accepted April 28, 2002 employment injury.[11] OWCP regulations provide that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination.[12] The Board will therefore remand the case for OWCP to refer appellant to an impartial medical examiner to determine whether the acceptance of her claim should be expanded to include the additional conditions of a disc herniation at L5-S1 causing left lumbar radiculitis, a cervical disc herniation, and/or degenerative disc disease causing left radiculitis at C5-6 causally related to her accepted employment injury.[13] Following this and any such further development as may be deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that the case is not in posture for decision.

[11] *See D.S.*, Docket No. 20-0146 (issued June 11, 2020); *W.B.*, Docket No. 17-1994 (issued June 8, 2018).

[12] 5 U.S.C. § 8123(a); *see also G.K.*, Docket No. 16-1119 (issued March 16, 2018).

[13] *See P.S.*, Docket No. 17-0802 (issued August 18, 2017).

ORDER

IT IS HEREBY ORDERED THAT the October 12, 2018 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: July 31, 2020
Washington, DC

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

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

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