United States Department of Labor
Employees' Compensation Appeals Board

H.H., Appellant	)	
and	)	**Docket No. 20-0839**
	)	**Issued: May 25, 2021**
U.S. POSTAL SERVICE, MENOMONIE POST OFFICE, Menomonie, MN, Employer	)	

Appearances:
Andrew Douglas, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 6, 2020 appellant, through counsel, filed a timely appeal from a February 18, 2020 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 met his burden of proof to establish a lumbar condition causally related to the accepted factors of his federal employment.

FACTUAL HISTORY

On October 19, 2016 appellant, then a 53-year-old rural carrier associate, filed an occupational disease claim (Form CA-2) alleging that he developed lower back facet sprain due to factors of his employment, including significant twisting motions required during mail delivery. He noted that he first became aware of this condition and its relationship to his employment duties on September 16, 2016. Appellant stopped work on October 5, 2016.

In an October 4, 2016 report, Dr. Darren K. Lokkesmoe, Board-certified in internal medicine, diagnosed mechanical low back pain with some mild lumbar nerve impingement symptoms. He related that appellant developed back pain approximately three weeks prior after feeling a pop in his back while delivering mail. Appellant's physical examination revealed positive straight-right leg raising.

An October 13, 2016 x-ray interpretation of appellant's lumbar spine revealed minimal L4_5 and L5-S1 degenerative changes.

Dr. Jay Loftsgaarden, a Board-certified physiatrist, reported on October 13, 2016 that appellant was seen for low back complaints and grinding pain radiating down the right leg. Appellant related that his pain began about a month previously while delivering mail, after he felt a pop in his back while twisting to the side. His physical examination findings included tenderness over the medial area to the right sacroiliac joint region, limited flexion, severe pain on back rotation or extension, limited internal left hip rotation with pain in the groin region and some over the femoral head, mild right hip range of motion, positive straight leg raising on the right, and full bilateral ankle and knee range of motion. Dr. Loftsgaarden diagnosed facet sprain, degenerative facet arthritis, and degenerative disc disease, which occurred in context of appellant's mail carrier job, which required constant turning to the left. Additionally, he noted that there were elements of radiculopathy. In a duty status report (Form CA-17) of even date, Dr. Loftsgaarden diagnosed lumbar facet sprain, which he attributed to appellant's work. He advised that appellant was disabled from work.

On October 21, 2016 Dr. Loftsgaarden reviewed x-ray interpretations and provided examination findings. He found appellant's symptoms were now more consistent with a diagnosis of radiculopathy. In a form report of even date, Dr. Loftsgaarden diagnosed lumbar radiculopathy and indicated by check mark that it was work related. He placed appellant off work pending further evaluation.

An October 25, 2016 x-ray report of appellant's lumbar spine related findings of L4-5 and L5-S1 broad-based posterior bulges and mild L4-5 neural foraminal narrowing.

In November 10, 2016 development letter, OWCP informed appellant that the evidence of record was insufficient to establish his claim. It advised him of the type of factual and medical

evidence needed and provided a questionnaire for his completion. OWCP afforded appellant 30 days to submit the necessary evidence.

OWCP subsequently received additional evidence. Dr. Loftsgaarden, in a November 3, 2016 report, noted appellant's continued pain complaints. Review of appellant's magnetic resonance imaging (MRI) scan revealed some L4-5 and L5-S1 mild foraminal stenosis. Dr. Loftsgaarden found appellant's dorsiflexor weakness was suggestive of L5 radiculopathy. He concluded that appellant was to remain off work.

In form reports from dated November 3, 17, and December 8, and 27, 2016, Dr. Loftsgaarden diagnosed lumbar radiculopathy and indicated by checking a box marked "Yes" that the diagnosed conditions were work related. He placed appellant off work pending further evaluation.

In a December 8, 2016 report, Dr. Loftsgaarden indicated that appellant's condition looked more likely related to facet arthritis, but there was a suggestion of a discogenic-type problem based on appellant's pain relief following injections. Physical examination findings included limited back extension and flexion and normal lower limbs strength.

In a December 12, 2016 report, Dr. Loftsgaarden noted that he had seen appellant five times since an initial evaluation on October 13, 2016. Appellant related developing pain and feeling a pop in his back after twisting in his employment vehicle. The initial diagnosis was facet sprain the setting of facet degenerative arthritis and degenerative disc disease. Dr. Loftsgaarden reviewed an MRI scan, which showed minor disc bulges and arthritis. He found appellant disabled from work due to his inability to perform the twisting required in his job.

A December 29, 2016 MRI scan revealed mild degenerative sacroiliac joint changes and no significant changes suggest of synovitis or infection.

By decision dated January 11, 2017, OWCP denied appellant's occupational disease claim, finding that the medical evidence of record was insufficient to establish that his diagnosed lumbar condition was causally related to the accepted factors of his federal employment.

OWCP received a January 10, 2017 report from Dr. Terry K. Schiefer, a Board-certified neurological surgeon, who diagnosed right-sided L5-S1 radiculopathy, right-sided L4-5 moderate lateral recess stenosis, right-sided L5-S1 mild-to-moderate lateral recess stenosis, low back pain, and right lower extremity weakness. Under history of injury, Dr. Schiefer noted that appellant initially felt a twinge in his back while working and subsequently felt a signficant pop in his back. Since the incident, appellant reported having severe back pain radiating into this lower extremities, greater on the right. Dr. Schiefer recommended right-sided L4-5 and L5-S1 hemilaminectomy and possible discetomy based on appellant's symptoms, diagnostic test, and examination findings.

A hospital record reflects that appellant underwent a surgical procedure on January 19, 2017 with preoperative and postoperative diagnoses of L5 and S1 right-sided radiculopathies, L5-S1 right-sided disc protrusion, and L4-5 and L5-S1 right-sided laeral recess stenosis. January 19, 2017 x-ray interpretation of appellant's lumbar spine noted a history of radiculopathy and impression of L4-5 and L5-S1 hemilaminectomy with L5-S1 discectomy.

In progress notes dated January 20, 2017, Dr. Schiefer diagnosed right lower extremity weakness, right-sided L5-S1 radiculopathy, right-sided L4-5 moderate lateral recess stenosis, right-sided L5-S1 mild-to-moderate lateral recess stenosis, low back pain, and stauts post right-sided L4-5 and L5-S1 hemilaminectomy and L5-S1 microdiscetomy, which was performed on January 19, 2017. Appellant related significant improvement in his pain following the surgery.

Dr. Schiefer, in a January 26, 2017 report, advised that appellant was seen on January 10, 2017 for lumbar complaints. Appellant described that, since September 2016, he had severe low back pain radiating mainly into the right lower extremity. Since appellant had not responded to conservative treatment, Dr. Schiefer performed L4-5 right-sided hemilamenctomy and microdiscectomy surgery on January 19, 2016. He attributed appellant's L4-5 radiculopathy symptoms and surgery to the accepted employment factors.

On February 3, 2017 appellant requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review, which was held on July 18, 2017.

Appellant submitted additional evidence. In progress notes dated February 23, 2017, Dr. Donald T. Bodeau, a Board-certified occupational medicine physician, related that appellant had been in good health until sustaining a work injury on September 16, 2016 when he felt a pull in his lower back while delivering mail. He noted appellant's physical examination findings and diagnosed significant postlaminectomy back and radicular pain and status post 1 level microdiscectomy, and 2 level hemilaminectomy. Dr. Bodeau related that appellant would be disabled from work for at least three months.

Dr. Bodeau, in a February 24, 2017 report, noted that appellant had a history of mild prior back pain, which generally was self-limited, as well as employment-related events occurring between September 16 and 30, 2016. Review of MRI scans taken on August 14, 2009 and on October 27, 2016 showed substantial structural changes. Dr. Bodeau attributed the change to appellant's employment injury. He opined that appellant's diagnosed disc herniation and lumbar radiculopathy were unquestionably caused by the accepted September 2016 employment factors. Dr. Bodeau explained that appellant's work aggravated, precipitated, and accelerated his underlying back condition beyond the normal progression of the disease.

A February 17, 2017 MRI scan revealed small focal lumbosacral central disc protrusion, postoperative changes left L5 hemilaminectomy new when compared with the October 27, 2016 MRI scan, and no spinal canal narrowing or neural foraminal narrowing at any level.

In reports dated March 10 and 31, 2017, Dr. Stephen M. Endres, a Board-certified anesthesiologist, diagnosed lumbar radiculitis, radiculopathy, and status post L5-S1 surgery.

Dr. Bodeau, in progress notes dated April 17, 2017, related that appellant was seen for postlaminectomy back pain and that he had been referred to the pain clinic for a spinal cord stimulator.

In progress notes dated May 12, 2017, Dr. Bodeau noted that appellant continued to complain of back and radicular pain and that he currently used a cane due to leg weakness.

Dr. Bodeau, in progress notes dated June 9, 2017, reported that appellant was doing well following implantation of a temporary spinal cord stimulator.

By decision dated October 2, 2017, OWCP's hearing representative affirmed the January 11, 2017 decision denying appellant's claim.

OWCP continued to receive medical evidence. In progress notes dated July 31, 2017, Dr. Bodeau related examination findings and noted that appellant remained disabled. Diagnoses included persistent postlaminectomy back pain status post spinal cord stimulator implantation complicated by development of pulmonary embolus and pneumonia.

Dr. Bodeau, in progress notes dated September 8, 2017, noted that appellant reported substantial improvement in his leg and back pain and that he had not developed any additional pulmonary emboli. Physical findings included an antalgic gait, negative straight leg raising, and has trouble with tiptoe gait.

In progress notes dated October 20, 2017, Dr. Bodeau summarized appellant's medical history. He noted that appellant had experienced some mechanical back issues in 2009, but no radicular or leg symptoms. Dr. Bodeau opined that the frequent repetitive lifting and twisting required in appellant's job most likely aggravated, accelerated, and precipitated his underlying back condition beyond the normal progression and created appellant's back and radicular leg pain, need for surgery, and associated care.

In an October 25, 2017 report, Dr. Bodeau related that appellant had been under his care for treatment of his occupational back injury, resulting lumbar laminectomy, and spinal cord stimulator. He noted that appellant provided a consistent history of injury involving repetitive lifting, bending, and twisting in sorting and delivering mail. Dr. Bodeau noted that, while appellant may have had a preexisting back condition, the incident occurring on or about September 16, 2016 clearly aggravated, accelerated, and precipitated his underlying condition beyond its normal progression.

In progress notes and a form report dated November 1, 2017, Dr. Bodeau opined that appellant had reached a plateau. He indicated that appellant was capable of working no more than four hours a day in a sedentary position. Work restrictions included: no lifting more 10 pounds; rare bending, kneeling, squatting, twisting, climbing, and reaching above the shoulders; occasional forward reaching; and the ability to change his position every half hour as needed. Dr. Bodeau noted that appellant would require use of a cane and knee brace.

In progress notes dated March 9, 2018, Dr. Bodeau reiterated findings from his prior reports. He opined that appellant was permanently and totally disabled from any physically demanding employment.

In progress notes dated April 19, 2018, Melissa C. Brown, an advanced practice registered nurse, noted that appellant was seen for back pain. She diagnosed right-sided L5-S1 radiculopathy, right-sided L4-5 moderate lateral recess stenosis, low back pain, right-sided L5-S1 mild-to-moderate lateral recess stenosis, right lower extremity weakness, and status post right-sided L4-5 and L5-S1 hemilaminectomy and L5-S1 microdiscectomy.

On May 22, 2018 appellant requested reconsideration.

By decision dated October 15, 2018, OWCP denied modification, finding that the medical evidence of record was insufficiently rationalized to establish causal relationship between the diagnosed conditions and the accepted employment factors.

On December 18, 2018 appellant requested reconsideration and submitted additional evidence.

In a report dated November 28, 2018, Dr. Michael Fitzgerald, an occupational medicine specialist Board-certified in family medicine, noted that appellant sustained a back injury due to his employment as a rural letter carrier. He explained that appellant's job duties required frequent awkward positions twisting, reaching, lifting, pulling, and bending, which contributed to the diagnosed L5-S1 lumbar disc herniation. Dr. Fitzgerald noted that appellant had previously been treated for a 2009 back injury. He compared the MRI scans taken at the time, which showed mild L5-S1 disc bulge with early disc desiccation and no neural foraminal or spinal canal compromise, with an MRI scan following the 2016 injury, which showed L4-5 and L5-S1 disc bulging progression with L4-5 disc abutting the L5 nerve on the right. Dr. Fitzgerald opined that appellant's work activities accelerated, aggravated, and precipitated chronic lumbar degenerative disc disease resulting in disc herniation.

By decision dated February 13, 2019 OWCP denied modification.

On March 27, 2019 appellant requested reconsideration.

By decision dated April 19, 2019, OWCP denied appellant's request for reconsideration as he failed to identify the grounds for his request or submit any evidence in support of his request.

OWCP subsequently received a November 12, 2019 report, wherein Dr. Fitzgerald noted that on November 28, 2018 he had taken over appellant's care and treatment following Dr. Bodeau's retirement. Dr. Fitzgerald related that appellant sustained a back injury on September 16, 2016 as a result of his rural mail carrier duties. Appellant's job duties required frequent twisting of the back, pulling, reaching, and lifting up to 70 pounds. On the date of injury he related that he felt a pop in his lower lumbar area and bilateral leg numbness while performing his work duties. Dr. Fitzgerald summarized the treatment provided, including diagnostic test results, surgery, and cord stimulator implantation. He reported that following implantation of the spinal cord stimulator that appellant developed a pulmonary embolism, chest pain, and fever. Diagnoses included lumbar disc disease with right-sided L5 and S1 radiculopathies and postlaminectomy syndrome, which he attributed to the accepted September 16, 2016 work incident. In support of this conclusion, Dr. Fitzgerald explained that the twisting, bending, turning, and lifting aggravated appellant's chronic lumbar degenerative disc disease beyond its normal course. This aggravation was caused by significantly increased pressure on the intervertebral discs causing new or worsening protrusions, which in turn caused radiculopathy and nerve impingement from the protrusion into disc material. Dr. Fitzgerald indicated that his opinion and findings were supported by the progressive changes noted on MRI scans, initial physical examination findings, and symptoms. Regarding appellant's 2009 treatment for back pain, Dr. Fitzgerald noted that his symptoms had resolved with physical therapy and no back pain had been reported in a

December 2015 visit. Moreover, appellant was asymptomatic until performing the repetitive rural mail carrier duties. Dr. Fitzgerald opined that the January 19, 2017 surgery and spinal cord stimulator were medically necessary to treat his condition. He concurred with Dr. Bodeau's opinion that appellant was permanently and totally disabled from work.

On November 27, 2019 appellant, through counsel, requested reconsideration.

By decision dated February 18, 2020, OWCP denied modification.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] has the burden of proof to establish the essential elements of his or her claim, including 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 of FECA,[4] that an injury was sustained in the performance of duty as alleged, and that any disability or medical condition for which compensation is claimed is causally related to the employment injury.[5] These are the essential elements of each and every compensation claim, regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[6]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant.[7]

Causal relationship is a medical issue, and the medical evidence required to establish causal relationship is rationalized medical evidence.[8] The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable medical

[3] *Id.*

[4] *C.G.*, Docket No. 20-0957 (issued January 27, 2021); *J.W.*, Docket No. 18-0678 (issued March 3, 2020); *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

[5] *J.S.*, Docket No. 18-0657 (issued February 26, 2020); *J.M.*, Docket No. 17-0284 (issued February 7, 2018); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[6] *L.J.*, Docket No. 19-1343 (issued February 26, 2020); *R.R.*, Docket No. 18-0914 (issued February 24, 2020); *Delores C. Ellyett*, 41 ECAB 992 (1990).

[7] *C.G.*, *supra* note 4; *S.C.*, Docket No. 18-1242 (issued March 13, 2019); *R.H.*, 59 ECAB 382 (2008).

[8] *A.M.*, Docket No. 18-1748 (issued April 24, 2019); *T.H.*, 59 ECAB 388, 393 (2008); *Robert G. Morris*, 48 ECAB 238 (1996).

certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and specific employment factors identified by the employee.[9]

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.[10]

ANALYSIS

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

In support of his claim, appellant provided narrative medical reports from Dr. Fitzgerald dated November 28, 2018 and November 12, 2019. Dr. Fitzgerald related appellant's complaints of lumbar pain and bilateral lower extremity numbness after September 16, 2016. He summarized appellant's medical treatment and physical examination findings. Dr. Fitzgerald diagnosed lumbar disc disease with right-sided L5 and S1 radiculopathies and postlaminectomy syndrome, which he attributed to appellant's employment. In both reports, he opined that appellant's 2009 back condition was exacerbated by his employment duties, which included repetitive frequent twisting of the back, pulling, reaching, and lifting up to 70 pounds. In the November 12, 2019 report, Dr. Fitzgerald further noted appellant's history regarding September 16, 2016 and explained that twisting, bending, turning, and lifting caused significantly increased pressure on the intervertebral discs causing new or worsening protrusions, which, in turn, caused radiculopathy and nerve impingement from the protrusion into disc material. In addition, he related that appellant's 2009 back condition had been successfully treated by physical therapy with no symptoms or reports of pain until September 16, 2016. Moreover, a review of appellant's MRI scans showed a significant progression of the underlying lumbar disc bulge from the mild lumbar disc bulge shown on the 2009 MRI scan.

It is well established that proceedings under FECA are not adversarial in nature and, while appellant has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[11] OWCP has an obligation to see that justice is done.[12]

The Board finds that Dr. Fitzgerald's opinion demonstrates his knowledge of appellant's preexisting lumbar conditions and, although his opinion is not sufficiently rationalized to meet

[9] *R.G.*, Docket No. 18-0792 (issued March 11, 2020); *D.J.*, Docket No. 19-1301 (issued January 29, 2020); *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013); *J.D.*, Docket No. 20-0404 (issued July 22, 2020); *K.G.*, Docket No. 18-1598 (issued January 7, 2020); *M.S.*, Docket No. 19-0913 (issued November 25, 2019).

[11] *See J.P.*, Docket No. 19-1206 (issued February 11, 2020); *M.G.*, Docket No. 18-1310 (issued April 16, 2019); *Walter A. Fundinger, Jr.*, 37 ECAB 200, 204 (1985).

[12] *See J.P., id.*; *C.M.*, Docket No. 17-1977 (issued January 29, 2019); *A.J.*, Docket No. 18-0905 (issued December 10, 2018); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983); *Gertrude E. Evans*, 26 ECAB 195 (1974).

appellant's burden of proof to establish his claim, it is sufficient to require further development of the case by OWCP.[13]

Therefore, the Board finds that the case shall be remanded to OWCP. On remand OWCP shall prepare a statement of accepted facts, the medical evidence of record, and appellant to a specialist in the appropriate field of medicine for a second opinion evaluation. Upon referral, the physician shall conduct a physical examination and provide a rationalized medical opinion as to whether appellant's lumbar conditions were caused or aggravated by factors of his employment. If the second opinion physician opines that the diagnosed conditions are not causally related, he or she must explain with rationale how or why the opinion differs from that of Dr. Fitzgerald's reports. Following this, and any other further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the February 18, 2020 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with decision of the Board.

Issued: May 25, 2021
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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

[13] *See J.P., id.*; *D.S.*, Docket No. 17-1359 (issued May 3, 2019); *C.W.*, Docket No. 17-1293 (issued February 12, 2018); *see also John J. Carlone*, 41 ECAB 354 (1989); *Horace Langhorne*, 29 ECAB 820 (1978).