United States Department of Labor
Employees' Compensation Appeals Board

C.L., Appellant	)	
and	)	**Docket No. 20-0213**
	)	**Issued: September 15, 2021**
FEDERAL DEPOSIT INSURANCE CORPORATION, Chicago, IL, Employer	)	

Appearances:
Stephen V. Barszac, 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 November 5, 2019 appellant, through counsel, filed a timely appeal from an October 10, 2019 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 the 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 that the acceptance of his claim should be expanded to include additional conditions as causally related to the accepted October 21, 2011 employment injury.

FACTUAL HISTORY

This case has previously been before the Board.[3] The facts and circumstances of the case as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On November 1, 2011 appellant, then a 50-year-old bank regulator, filed a traumatic injury claim (Form CA-1) alleging that, while in travel status on October 21, 2011, he injured his: wrists, left thumb and hand, left collar bone, right fingers, right shoulder, neck, thoracic and lumbar areas of the spine, right knee, and right heel when his vehicle was struck from the rear with great force. He stopped work that day. On March 22, 2012 OWCP accepted the claim for unspecified backache. On March 3, 2015 it expanded its acceptance of the claim to include lumbar sprain, and left wrist interphalangeal sprain.

By decision dated November 30, 2015, OWCP denied appellant's request to further expand the acceptance of the claim to include additional conditions.

Appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

By decision dated June 10, 2016, the hearing representative affirmed the November 20, 2015 OWCP decision. Appellant appealed to the Board.

By decision dated May 19, 2017, the Board affirmed the June 10, 2016 hearing representative's decision, finding that the medical evidence of record was insufficient to establish additional conditions as causally related to the accepted October 21, 2011 employment injury.[4]

On May 18, 2018 appellant, through counsel, requested reconsideration and submitted additional medical evidence.

In a February 6, 2012 operative report, Dr. Michael Bednar, Board-certified in orthopedic and hand surgery, described removal of a deep implant. His pre- and postoperative diagnoses were painful hardware, left distal radius. The history noted that appellant was status post an open reduction internal fixation of left distal radius in the distant past, and the hardware became painful.

[3] Docket No. 16-1567 (issued May 19, 2017).

[4] *Id*.

A March 26, 2012 magnetic resonance imaging (MRI) scan of appellant's lumbar spine revealed findings of mild degenerative facet hypertrophy, throughout the lumbar spine, with disc narrowing and disc desiccation also present throughout the lumbar spine.

An April 25, 2013 left knee MRI scan report noted a medial meniscus tear.[5]

On October 31, 2017 Dr. Anatoly M. Rozman, a Board-certified physiatrist, reported a history that appellant was in a motor vehicle accident (MVA) when his car was rear-ended. He related that he was taken to the hospital where he had an intensive workup. Dr. Rozman described examination findings, noting diminished left hand grip strength, positive Phalen's test and Tinel's sign in the left wrist with decreased sensation, with positive empty can and lift-off tests on the left. McMurray's test was positive on the left knee. Straight leg raising was positive with lumbar spasm and limited lumbar range of motion and decreased sensation in the L4-5 distribution. Cervical spine demonstrated pain to palpation with preserved range of motion. Dr. Rozman noted an antalgic gait on the right, and diminished big toe extension bilaterally. He indicated that appellant took over-the-counter medication for pain control, and presented no signs of symptom magnification or malingering. Dr. Rozman advised that appellant's lumbar disc disease and lumbar disc protrusion were causally related to the MVA due to an accelerating and decelerating injury with sudden flexion and extension of the lumbar spine. He further indicated that the left tendon rupture was also related to the MVA, noting appellant's report that upon sudden impact, he had severe flexion and extension of the left hand with excruciating pain and loss of range of motion. Dr. Rozman reported that extensive and appropriate workup was not done at the time of the MVA, and appellant's condition had now become chronic.

By decision dated August 13, 2018, OWCP denied modification of its prior decision.

On August 9, 2019 appellant, through counsel, requested reconsideration.

Counsel submitted a January 30, 2019 report in which Dr. J. Michael Morgenstern, an orthopedic surgeon, noted that appellant had been in a rear-end collision on October 21, 2011. He noted that in 2016 appellant had an unrelated traumatic injury in which he fractured his left foot and opined that this neither caused nor exacerbated appellant's other orthopedic injuries. Dr. Morgenstern noted that he saw appellant on August 6, 2018 with a complaint of constant lower back pain with sharp pain shooting to the lower extremities, and difficulty with activities of daily living. He related that, in reaction to the strong, violent thrusting motion produced by the MVA, appellant's left hand gripped the steering wheel forcefully, that his entire body forcefully jerked forward in a whip-lashing manner, and that he experienced immediate pain, swelling, and injuries to the lower back and left knee. Dr. Morgenstern noted that left wrist and hand examination demonstrated an old healed surgical scar, atrophy of the thenar region, a positive Finkelstein's test, and decreased range of motion, including painful thumb opposition. He noted an antalgic gait and found pain and spasm of the lumbar facets and paraspinal muscles. Straight test was positive, and lumbar range of motion diminished. Dr. Morgenstern further noted swelling of the left knee with mild discomfort on palpation and a positive Clarke's test. He diagnosed lumbar disc disease with radiculopathy, left thumb tendon rupture, and medial meniscus tear of the left knee. Dr. Morgenstern advised that the lumbar MRI scan performed on March 26, 2012 indicated that

[5] This was initially misidentified as a right knee MRI scan.

appellant's lumbar condition was discogenic and opined that it was most likely caused by the October 21, 2011 MVA. He explained that this would have caused two sudden accelerations of appellant's body, first backward, then forward which caused a load that was imparted on his spine causing one or more disc herniations. Dr. Morgenstern maintained that appellant's current lumbar findings were beyond what the normal progression would have been had it not been for the work injury. He noted that appellant's other physicians, including Dr. Rozman, agreed that appellant's lumbar condition was caused by the October 21, 2011 MVA. Dr. Morgenstern further maintained that Dr. Bednar's January 2012 surgery was performed to prevent continuing rupture of the tendon that began with the MVA. He explained that appellant's hyperextended wrist caused the tendon to partially rupture through contact with the metal implant in his wrist due to his body position and acceleration of his body backward and forward during the collision, as he would have been holding the steering wheel, concluding that the apparent and most probable cause of the ruptured tendon that controlled the left thumb was the October 21, 2011 MVA. As to the torn left knee medial meniscus, Dr. Morgenstern explained that, a torn medial meniscus most commonly occurs by twisting or hyperflexing the knee as a result of a single event, but in appellant's case, the history of onset over a period of weeks following the MVA indicated that it occurred through kinematic and kinetic changes during his gait cycle. He opined that shortening the mid-distance of appellant's previously normal walking gait as a result of pain and decreased motion due to his lower spine injury and the corresponding increased adduction, was the most probable cause of the meniscus tear. Dr. Morgenstern concluded, within a reasonable degree of medical certainty, that appellant's conditions were solely caused by the October 21, 2011 employment-related MVA.

By decision dated October 10, 2019, OWCP denied modification of its prior 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.[6]

To establish causal relationship, the employee must submit rationalized medical opinion evidence.[7] 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 accepted employment injury.[8] The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[9]

[6] *J.R.*, Docket No. 20-0292 (issued June 26, 2020); *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[7] *E.W.*, Docket No. 20-0338 (issued October 9, 2020).

[8] *L.P.*, Docket No. 20-0609 (issued October 15, 2020); *Leslie C. Moore*, 52 ECAB 132 (2000).

[9] *J.L.*, Docket No. 20-0717 (issued October 15, 2020); *James Mack*, 43 ECAB 321 (1991).

ANALYSIS

The Board finds this case not in posture for decision.

Preliminarily, the Board notes that it is unnecessary to consider the evidence appellant submitted prior to the issuance of OWCP's June 10, 2016 merit decision. The Board considered this evidence in its May 19, 2017 decision and found that it was insufficient to establish additional conditions as causally related to the October 21, 2011 employment injury.[10] Findings made in prior Board decisions are *res judicata* absent any further review by OWCP under section 8128 of FECA.[11]

On reconsideration appellant submitted a January 30, 2019 report from Dr. Morgenstern, who noted that appellant had been in a rear-end collision on October 21, 2011. Dr. Morgenstern noted that in 2016 appellant had an unrelated traumatic injury in which he fractured his left foot and opined that this neither caused nor exacerbated appellant's other orthopedic injuries. He noted that he saw appellant on August 6, 2018 with a complaint of constant lower back pain with sharp pain shooting to the lower extremities, and difficulty with activities of daily living. Dr. Morgenstern related that, in reaction to the strong, violent thrusting motion produced by the MVA, appellant's left hand gripped the steering wheel forcefully, that his entire body forcefully jerked forward in a whip-lashing manner, and that he experienced immediate pain, swelling, and injuries to the lower back and left knee. He noted that left wrist and hand examination demonstrated an old healed surgical scar, atrophy of the thenar region, a positive Finkelstein's test, and decreased range of motion, including painful thumb opposition. Dr. Morgenstern noted an antalgic gait and found pain and spasm of the lumbar facets and paraspinal muscles. Straight test was positive, and lumbar range of motion diminished. Dr. Morgenstern further noted swelling of the left knee with mild discomfort on palpation and a positive Clarke's test. He diagnosed lumbar disc disease with radiculopathy, left thumb tendon rupture, and medial meniscus tear of the left knee. Dr. Morgenstern advised that the lumbar MRI scan performed on March 26, 2012 indicated that appellant's lumbar condition was discogenic and opined that it was most likely caused by the October 21, 2011 MVA. He explained that this would have caused two sudden accelerations of appellant's body, first backward, then forward which caused a load that was imparted on his spine causing one or more disc herniations. Dr. Morgenstern maintained that appellant's current lumbar findings were beyond what the normal progression would have been had it not been for the work injury. He noted that appellant's other physicians, including Dr. Rozman, agreed that appellant's lumbar condition was caused by the October 21, 2011 MVA. Dr. Morgenstern further maintained that Dr. Bednar's January 2012 surgery was performed to prevent continuing rupture of the tendon that began with the MVA. He explained that appellant's hyperextended wrist caused the tendon to partially rupture through contact with the metal implant in his wrist due to his body position and acceleration of his body backward and forward during the collision, as he would have been holding the steering wheel, concluding that the apparent and most probable cause of the ruptured tendon that controlled the left thumb was the October 21, 2011 MVA. As to the torn left knee medial meniscus, Dr. Morgenstern explained that, while a torn medial meniscus most commonly occurs by twisting or hyperflexing the knee as a result of a single event, but in appellant's case, the history

[10] *Supra* note 3.

[11] *T.T.*, Docket No. 19-0319 (issued October 26, 2020); *Robert G. Burns*, 57 ECAB 657 (2006).

of onset over a period of weeks following the MVA indicated that it occurred through kinematic and kinetic changes during his gait cycle. He opined that shortening the mid-distance of appellant's previously normal walking gait as a result of pain and decreased motion due to his lower spine injury and the corresponding increased adduction, was the most probable cause of the meniscus tear. Dr. Morgenstern concluded, within a reasonable degree of medical certainty, that appellant's conditions were solely caused by the October 21, 2011 employment-related MVA.

In his January 30, 2019 report, Dr. Morgenstern relied upon a proper history of injury and provided a pathophysiological explanation as to how the accepted employment injury was sufficient to have caused additional diagnosed conditions. Accordingly, the Board finds that his opinion, while insufficiently rationalized to meet appellant's burden of proof, is sufficient, to require further development of the medical record as to whether additional conditions are causally related to the accepted employment injury.[12]

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.[13]

On remand OWCP shall refer appellant to a specialist in the appropriate field of medicine, along with the case record and a statement of accepted facts, for a well-rationalized opinion regarding whether appellant sustained additional conditions causally related to the accepted employment injury. If the physician opines that the additional conditions are not causally related to the accepted employment injury, he or she must explain with rationale how or why their opinion differs from that of Dr. Morgenstern. After this and such other further development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

The Board finds this case not in posture for decision.

[12] *See J.S.*, Docket No. 19-0892 (issued November 4, 2020); *E.J.*, Docket No. 09-1481 (issued February 19, 2010); *John J. Carlone*, 41 ECAB 354, 360 (1989).

[13] *T.S.*, Docket Nos. 20-1177 and 20-1296 (issued May 28, 2021).

ORDER

IT IS HEREBY ORDERED THAT the October 10, 2019 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: September 15, 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