United States Department of Labor
Employees' Compensation Appeals Board

D.W., Appellant	)	
and	)	**Docket No. 15-367**
	)	**Issued: July 14, 2015**
DEPARTMENT OF HOMELAND SECURITY, FEDERAL LAW ENFORCEMENT TRAINING CENTER, Glynco, GA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On December 8, 2014 appellant filed a timely appeal from a September 29, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[2]

ISSUE

The issue is whether appellant sustained additional neck and cervical conditions as a consequence of his accepted June 1, 2012 injury.

[1] 5 U.S.C. § 8101 *et seq.*

[2] Appellant submitted additional evidence on appeal. However, the Board cannot consider this evidence, however, as its review of the case is limited to the evidence of record which was before OWCP at the time of its final decision. 20 C.F.R. § 501.2(c); *see Steven S. Saleh*, 55 ECAB 169 (2003).

FACTUAL HISTORY

On June 1, 2012 appellant, then a 56-year-old senior instructor, was injured in his automobile when retractable security bollards (safety guards), at his duty station, unexpectedly raised under his vehicle as he was driving over them. His vehicle was lifted approximately four feet off the ground. Appellant noted having head, neck, spine, and breast bone pain. OWCP accepted the claim for lumbar sprain.

In a June 1, 2012 emergency room report, Dr. Jennifer Adair, Board-certified in emergency medicine, noted that appellant presented following a motor vehicle accident. Appellant reported pain between his scapulae. Dr. Adair examined appellant and noted that the neck had no midline tenderness although he was tender just left of the midline on the posterior neck. She found that he was tender over the mid thoracic spine and adjacent paraspinal muscles. Dr. Adair diagnosed a "muscle strain," a pulled muscle, chest wall pain and headache. A June 1, 2012 thoracic spine x-ray demonstrated degenerative changes of the thoracic spine with no fracture. A June 1, 2012 computerized tomography (CT) scan of the head revealed no acute intracranial process.

In a June 7, 2012 report, Dr. James McGrory, a Board-certified orthopedic surgeon, noted that appellant was driving his vehicle when "suddenly security bollards came up from the ground and stopped his car. He was jerked really hard." Dr. McGrory reported that, on the prior day, appellant noted that he felt his back pop and then suddenly felt better. He diagnosed lumbar sprain and strain and lumbago and muscle strain. Dr. McGrory noted appellant's had a prior history of shoulder and upper arm strains, including a complete rupture of a rotator cuff on January 7, 2009. OWCP also received several physical therapy reports.

In a December 6, 2012 report, Dr. Douglas Pahl, a Board-certified orthopedic surgeon and associate of Dr. McGrory, noted appellant's history of injury and treatment which included "pain since June when a high-powered and high velocity barrier device deployed inadvertently by apparently a lightning strike and destroyed his vehicle while he was driving [at] a relatively slow rate of speed." Since then appellant described interscapular pain, some neck pain and left arm pain radiating to the ulnar digits. Dr. Pahl stated that appellant did not currently have a lumbar strain and he did not describe any history of lumbar strain. He examined appellant and found that the neck was supple with full range of motion. X-rays of the thoracic spine revealed a significantly collapsed disc at C5-6 which possibly correlated with the radiating pain symptoms. Dr. Pahl found tenderness of the left parathoracic spine and recommended a magnetic resonance imaging (MRI) scan. He diagnosed thoracic spine pain, cervical spondylosis without myelopathy, cervicalgia, brachial neuritis or radiculitis, and thoracic spondylosis without myelopathy. Dr. Pahl advised that appellant's symptoms correlated with the accident and with possible cervical pathology.

In a letter dated December 31, 2012, appellant requested that OWCP approve his thoracic and cervical conditions and an MRI scan of the cervical area.

A January 25, 2013 thoracic spine MRI scan, read by Dr. Hyun M. Song, a Board-certified diagnostic radiologist, revealed T10-11 prominent ligamentum flavum hypertrophy and thickening on the left, abutting the left dorsal aspect of the cord; T9-10 central mixed spondylotic

protrusion with effacement of the ventral thecal sac; T5-6 small left parasagittal protrusion with effacement of the left ventral thecal sac; and lower cervical spondylosis with evidence of impingement of the ventral aspect of the cervical cord.

In a letter dated January 28, 2013, OWCP explained that it could not authorize the thoracic spine MRI scan without medical reasoning from his physician explaining how his current condition was related to the June 1, 2012 incident.

In a letter dated February 15, 2013, appellant repeated his request to authorize the cervical MRI scan and reiterated that his symptoms were from his accident. In a letter dated February 20, 2013, he explained that OWCP's acceptance or lumbar strain was an inadvertent oversight as he had not experienced any lumbar symptoms at the time of his original injury. Appellant noted that on his claim form he had indicated only head, neck and spine pain. He also noted that he received physical therapy from June through August 2012, which targeted his injured areas of the head, neck, and thoracic spine. Appellant argued that his physician, Dr. Pahl now provided a reasoned opinion to allow for the correct diagnoses to include his neck and thoracic spine.

In a February 21, 2013 report, Dr. Pahl noted appellant's history of injury and treatment. He advised that appellant was still having problems with the arms and the upper thoracic spine essentially stemming from the neck and advised that this "correlated with the work-related event." Dr. Pahl opined that he was not sure why the cervical spine MRI scan had not been authorized as it correlated with the work-related event and the MRI scan of the thoracic spine revealed that appellant's symptoms were worsening, including arm numbness. He explained that the imaging showed severe stenosis at C5-6 and C6-7, which correlated with the symptoms he was experiencing into the arms. Dr. Pahl diagnosed: pain in the thoracic spine; cervical spondylosis without myelopathy; cervicalgia; brachial neuritis or radiculitis; thoracic spondylosis without myelopathy; and spinal stenosis in the cervical region. He also again recommended approval of the cervical MRI scan.

In letters dated March 14 and 22, 2013, OWCP requested additional information related to appellant's request to expand his claim. It informed him of the type of evidence needed to support his claim and requested that he submit such evidence within 30 days.

In a March 27, 2013 report, Dr. Pahl opined that he believed the work-related event was "causally related to the C-spine MRI scan findings revealing severe cervical spondylosis and stenosis recently visible on the thoracic spine MRI [scan]."

By decision dated June 18, 2013, OWCP denied appellant's request to expand his claim. It found that the attending physician had not provided any rationale or reasoning to establish additional conditions caused or aggravated by the June 1, 2012 incident.

On July 1, 2013 appellant requested a hearing. This was later changed to a request for a telephone hearing which was held on February 24, 2014.

An August 2, 2013 MRI scan of the cervical spine read by Dr. Matthew P. Chanin, a Board-certified diagnostic radiologist, revealed severe central canal stenosis, cerebrospinal fluid column effacement; moderate foraminal stenosis due to disc osteophyte, uncovertebral and facet

hypertrophy, central herniated nucleus pulposus (HNP) at C6-7, with no cord signal abnormality; severe central canal stenosis due to disc osteophyte; small superimposed disc protrusion without cord signal abnormality at C5-6; moderate left and mild right neural foraminal stenosis due to uncovertebral and facet hypertrophy at C4-5 accompanied by moderate central canal stenosis; and mild-to-moderate central canal stenosis due to disc osteophyte complex formation, accompanied by mild bilateral neural foraminal stenosis at C3-4.

On August 7, 2013 appellant requested that the claim be expanded. He included a new report from Dr. Pahl dated August 2, 2013. Dr. Pahl noted appellant's history, which included significant spinal cord stenosis and impingement at C5-6 and C6-7, and believed those factors correlated with his symptoms. He noted that appellant did not have any specific pain before the work incident in his neck or upper thoracic area, which began after the accident. Dr. Pahl advised that

> "This is clearly related. These are severe disc herniations which are fairly easily correlated with this event. I am unsure why there has been an actual question about this particular event and the location of pain. He never really had any lumbar spine pain although he was initially sent for an evaluation of the lumbar spine. I have never found any pathology in the lumbar spine and found that it was obvious at the cervical spine and mid thoracic levels. The disc herniations can be easily correlated with the high-level injury imported to his neck with the violent mechanism of injury."

Dr. Pahl recommended surgery. He diagnosed brachial neuritis or radiculitis; cervical spinal stenosis; cervical spondylosis without myelopathy; thoracic spondylosis without myelopathy; and cervicalgia.

Appellant continued to submit additional medical evidence. In an August 13, 2013 report, Dr. Pahl advised that appellant denied any prior neck or thoracic spine complaints prior to the work-related event. He found that the mechanism of injury correlated with the current history, examination and radiographic findings, "more likely than not." Dr. Pahl recommended a cervical decompression and fusion with instrumentation at C5-6, C6-7 to decompress the spinal cord. He recommended no activity other than answering telephones and that appellant undergo surgery as soon as possible. Dr. Pahl advised that appellant was dangerously at risk for quadriplegia. On October 9, 2013 he performed an anterior cervical discectomy with decompression and fusion, anterior interbody device placement augmented with cancellous allograft plugs, C5-6 and C6-7, anterior plate stabilization and instrumentation C5 to C7 and spinal cord monitoring. Dr. Pahl continued to treat appellant. OWCP also received x-ray photographs of appellant's cervical region.

In a letter dated February 25, 2014, appellant reiterated his request to expand his claim. He noted that he had initially complained of head, neck and back pain. Appellant also noted that x-rays were taken of his thoracic spine because "that was where the majority of the pain was." He also indicated that from the end of June to August 2012, he received 22 physical therapy treatments "targeting his thoracic area because that was where the pain was." Appellant also explained that he requested to see Dr. Pahl, a spine specialist, but he was unavailable for six

weeks, and he did not receive authorization to see him from OWCP until November 5, 2012.[3] He noted that it was almost four months before he received approval and that was why his first appointment was scheduled for December 6, 2012. Appellant argued that OWCP's delay in authorizing Dr. Pahl's treatment was the reason for not obtaining treatment sooner for his cervical and thoracic condition.

By decision dated April 22, 2014, an OWCP hearing representative affirmed the June 18, 2013 decision. She found that there was no explanation as to what occurred during the six-month time frame when appellant was not seen by a physician. The hearing representative found that it was unclear how a severe neck injury could flare up six months after the motor vehicle incident.

On July 30, 2014 OWCP received appellant's request for reconsideration. He submitted photographs of his automobile after the June 1, 2012 accident.

In a June 17, 2014 report, Dr. Pahl explained that appellant had no prior neck pain and was involved in a severe and significant collision with his motor vehicle and a barricade that "deployed directly beneath his vehicle he was driving as he passed through a security gate. This forcibly advanced his skull into the metal headliner of his vehicle causing a significant axial load injury to his neck with a hyperflexion moment." Dr. Pahl opined:

> "[Appellant's] subsequent studies to include a thoracic AND cervical MRI revealed OBVIOUS cervical disc herniations CAUSING spinal cord stenosis and impingement which were recommended for surgery. In my expert opinion, the stenosis, disc herniations, spinal cord impingement were directly and causally related to the incident described AND the surgery outlined/ recommended and performed was specifically to treat these injuries AND medically/surgically indicated." (Emphasis in the original.)

Dr. Pahl noted that he identified a small amount of preexisting degenerative disc disease, but it was extremely slight and appellant was asymptomatic. He stated that he could not be more clear as to the cause of these cervical conditions.

By decision dated September 29, 2014, OWCP denied modification of its prior decision.

LEGAL PRECEDENT

The general rule respecting consequential injuries is that, when the primary injury is shown to have arisen out of and in the course of employment, every natural occurrence that flows from the injury is deemed to arise out of the employment, unless it is the result of an independent intervening cause, which is attributable to the employee's own intentional conduct.[4] The subsequent injury is compensable if it is the direct and natural result of a compensable

[3] The record indicates that, on June 11, 2012, appellant requested that OWCP authorize his treatment by Dr. Pahl. On November 5, 2012 OWCP authorized Dr. Pahl to treat appellant.

[4] *Albert F. Ranieri*, 55 ECAB 598 (2004).

primary injury.[5] With respect to consequential injuries, the Board has stated that, where an injury is sustained as a consequence of an impairment residual to an employment injury, the new or second injury, even though nonemployment related, is deemed, because of the chain of causation, to arise out of and in the course of employment and is compensable.[6] A claimant bears the burden of proof to establish the claim for consequential injury.[7]

Causal relationship is a medical issue,[8] and the medical evidence generally required to establish causal relationship is rationale medical opinion evidence. The opinion of the physician must be based on a complete factual and medical history of the claimant,[9] must be one of reasonable certainty,[10] and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the established incident or factor of employment.[11]

ANALYSIS

In this case, OWCP accepted appellant's claim for sprain of the back, lumbar region. Appellant asked that his claim be expanded to include a thoracic and cervical condition. However, OWCP denied his request to expand his claim for a consequential injury.

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

The evidence in this case supports that on the date of the incident, appellant had complaints of head, neck, spine, and breast bone pain after the vehicle in which he was driving was lifted three to four feet in the air when it was struck by retractable security bollards. Furthermore, the emergency room notes from Dr. Adair on June 1, 2012 contain findings which include that the neck was tender just left of the midline on the posterior neck. She found that the back was tender over the mid thoracic spine and adjacent paraspinal muscles. Dr. Adair diagnosed a "muscle strain," a pulled muscle, chest wall pain and headache. Appellant explained that he received physical therapy from June to August 2012, which focused on his thoracic area and also explained that he did not see Dr. Pahl earlier because he did not receive authorization from OWCP until four months after the injury.

The evidence offered in support of expansion of appellant's claim includes several reports from Dr. Pahl. In his initial December 6, 2012 report, Dr. Pahl noted appellant's history of injury and explained that appellant described interscapular pain, neck pain and left arm pain

[5] *Id.; Carlos A. Marrero*, 50 ECAB 117 (1998); A. Larson, *The Law of Workers' Compensation* § 10.01 (2005).

[6] *Kathy A. Kelley*, 55 ECAB 206 (2004); *see also C.S.*, Docket No. 11-1875 (issued August 27, 2012).

[7] *S.P.*, Docket No. 14-900 (issued August 8, 2014).

[8] *Mary J. Briggs*, 37 ECAB 578 (1986).

[9] *William Nimitz, Jr.*, 30 ECAB 567 (1979).

[10] *See Morris Scanlon*, 11 ECAB 384, 385 (1960).

[11] *See William Enright*, 31 ECAB 426, 430 (1980).

radiating to the ulnar digits. He believed that the lumbar condition had been inadvertently diagnosed. Dr. Pahl noted that thoracic spine x-rays showed a significantly collapsed disc at C5-6 which possibly correlated with the neck and radiating arm symptoms. He opined that appellant's symptoms correlated with the accident. Dr. Pahl repeated his opinion in his February 21, 2013 report and explained that the thoracic spine MRI scan indicated severe stenosis at C5-6 and C6-7 which correlated with appellant's symptoms. In an August 2, 2013 report, he indicated that appellant did not have any specific pain in his neck or upper thoracic area before the work injury and opined that "[t]his is clearly related. These are severe disc herniations which are fairly easily correlated with this event." Dr. Pahl explained that the "disc herniations could be easily correlated with the high-level injury imported to his neck with the violent mechanism of injury." In his August 13, 2013 report, he indicated that the mechanism of injury correlated with the current history, examination and radiographic findings, "more likely than not." Dr. Pahl recommended a cervical decompression and fusion at C5-6, C6-7. In his June 17, 2014 report, he explained that appellant did not have neck pain prior to the accident and that he was involved in a severe and significant motor vehicle incident which "forcibly advanced his skull into the metal headliner of his vehicle causing a significant axial load injury to his neck with a hyperflexion moment." Dr. Pahl opined: "[Appellant's subsequent studies to include a thoracic AND cervical MRI scan revealed OBVIOUS cervical disc herniations CAUSING spinal cord stenosis and impingement which were recommended for surgery." He advised that "the stenosis, disc herniations, spinal cord impingement were directly and causally related to the incident described AND the surgery outlined/ recommended and performed was specifically to treat these injuries AND medically/surgically indicated." (Emphasis in the original.) Dr. Pahl noted that he identified a small amount of preexisting degenerative disc disease but extremely slight and asymptomatic.

Proceedings under FECA are not adversarial in nature nor is OWCP a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence to see that justice is done.[12] While Dr. Pahl's reports do not contain sufficient rationale to discharge appellant's burden of proving by the weight of the reliable, substantial and probative evidence that his cervical and thoracic condition was caused or aggravated by factors of his employment, they reflect an accurate history, detailed diagnostic findings and are supported by sufficient rationale to require further development of the case record by OWCP.[13]

On remand, OWCP should refer appellant, the case record, and a statement of accepted facts to an appropriate Board-certified specialist for an evaluation and a rationalized medical opinion regarding the cause of appellant's condition. After such further development of the case record as it deems necessary, a *de novo* decision shall be issued.

Appellant made several arguments on appeal to support his claim. However, in light of the Board's finding, it is premature to address them at this juncture.

[12] *William J. Cantrell*, 34 ECAB 1223 (1983).

[13] *See John J. Carlone*, 41 ECAB 354 (1989); *Horace Langhorne*, 29 ECAB 820 (1978).

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the September 29, 2014 decision of the Office of Workers' Compensation Programs is set aside and remanded for action consistent with this decision.

Issued: July 14, 2015
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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