United States Department of Labor
Employees' Compensation Appeals Board

C.L., Appellant	)	
and	)	**Docket No. 21-0729**
	)	**Issued: December 1, 2022**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Chamblee, GA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

JURISDICTION

On April 16, 2021 appellant, through counsel, filed a timely appeal from a March 15, 2021 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 her burden of proof to establish that the acceptance of her claim should be expanded to include the additional conditions of mild thickening of the right distal biceps tendon, diffuse degenerative disc disorder L4-5 and L5-S1, severe central canal stenosis at L4-5, mild-to-moderate central canal stenosis and right lateral recess narrowing at L5-S1, bilateral foraminal stenosis L5-S1, and lumbar degenerative disc disorder.

FACTUAL HISTORY

On June 7, 2013 appellant, then a 53-year-old tax compliance officer, filed a traumatic injury claim (Form CA-1) alleging on that day she fell on the granite lobby floor and hit both of her knees and her right elbow while in the performance of duty. She returned to light duty and worked until August 16, 2013.[3] OWCP initially accepted the claim for right elbow contusion and bilateral knee contusions.

On August 13, 2018 appellant, through counsel, requested that the acceptance of her claim be expanded to include the additional conditions of mild thickening of the right distal biceps tendon, right elbow ligament tear, right elbow radial collateral ligament and extensor tendon tear, low back strain/sprain, diffuse degenerative disc disorder L4-5 and L5-S1, severe central canal stenosis at L4-5, mild-to-moderate central canal stenosis and right lateral recess narrowing at L5-S1, bilateral foraminal stenosis L5-S1, and lumbar degenerative disc disorder.

In an August 14, 2013 report, Dr. Philip N. Henderson, a Board-certified occupational medicine specialist, noted appellant's history of injury and diagnosed lumbago and enthesopathy of elbow region.

A magnetic resonance imaging (MRI) scan of appellant's lumbar spine, dated October 3, 2013, related an impression of spondylitic changes at L4-S1 age determinate; L4-5 disc bulge with broad central protrusion and facet arthropathy, with moderate-to-severe central canal stenosis; L5-S1 advanced disc desiccation with right eccentric disc bulge and right central protrusion which severely narrowed the right lateral recess; mild-to-moderate central canal stenosis and moderate left greater than right foraminal stenosi; and suspect old right hemilaminotomy at the L5-S1 level.

In a December 2, 2013 report, Dr. Ned B. Armstrong, a Board-certified orthopedic surgeon, related that regarding appellant's right biceps pathology, typically distal biceps tendon pathology was caused by a hyperextension injury to the elbow, but appellant had explained that she intentionally did not fall on an outstretched hand or wrist because she did not want to break her wrist, therefore she bent her elbow and landed on the ulnar border of her forearm. Regarding appellant's lumbar pathology, he opined that an acute soft tissue injury to the paraspinal muscles, fascia, and aggravation of a preexisting condition were all likely contributing to her clinical complaints. Dr. Armstrong indicated that lumbar surgery for disc pathology may be an option, although he could not explicitly separate the findings from the recent injury and those from the

[3] Appellant was off work from August 19 to September 21, 2013 for nonwork-related reasons and off work from September 22, 2013 and continuing for an indefinite administrative suspension. On February 21, 2014 her was separated from the employing establishment for administrative reasons.

lumbar laminectomy and discectomy in 1993. He noted that there did not appear to be any annular ligament injury of the involved site of lumbar disc pathology that could correlate with the L4-5 and L5-S1 degenerative changes which would indicate her clinical complaints and findings were only from an acute injury rather than exacerbation of antecedent degenerative changes at those levels. Dr. Armstrong further indicated that the presence of stenosis at those two levels could be a comorbidity that can accelerate and exaggerate the irritation of the adjacent neurogenic and non-neurogenic soft tissue and facet joints from the fall.

In a December 16, 2013 report, Dr. Armstrong noted that he could not exclude aggravation of antecedent degenerative changes of the lower lumbar area for which she had discectomy L5-S1 on right side in 1993. He explained that appellant was dealing with an acute soft tissue injury with aggravation of antecedent degenerative changes. Dr. Armstrong also indicated that the presence of stenosis at the L4-5 and L5-S1 levels could be accelerating or exaggerating comorbidity and was responsible for the duration and intensity of her pain related to the June 2013 fall.

In a March 3, 2014 report, Dr. Armstrong noted that appellant had completed physical therapy, but she felt that her back pain had worsened since June 2013. He indicated that her chronic strain/sprain syndrome with antecedent degenerative changes may have been aggravated by the work-related injury. Dr. Armstrong opined that there could be a direct causal relationship between appellant's fall and her lumbar strain/sprain syndrome; however, he could not confirm that her soft tissue pathology had subsided, and that the natural course of degenerative arthrosis was now dominating her complaints.

In a January 4, 2016 medical report, Dr. Princewill U. Ehirim, a Board-certified neurosurgeon, noted that appellant's low back symptoms had been present since 2013. He reviewed a June 2015 magnetic resonance imaging (MRI) scan and indicated that it showed postoperative changes of a previous right L5-S1 microdiskectomy; a right-sided disc herniation, which resulted in effacement of the thecal sac and the right S1 nerve root; and a large L4-5 disc herniation which, together with posterior element hypertertrophy, resulted in central canal stenosis. Dr. Ehirim provided diagnoses of other intervertebral disc degeneration, lumbar region and spondylosis without myelopathy or radiculopathy, lumbosacral region.

In a June 1, 2018 report, Dr. Amit S. Patel, a Board-certified physiatrist, diagnosed lumbar radiculopathy and chronic pain syndrome. He indicated that although appellant had a history of a lumbar discectomy or laminectomy surgery approximately 20 years prior to her work injury, it was more likely than not that her current low back pain and radiculopathy were causally related to the 2013 injury. Dr. Patel explained that the conditions for which surgery was performed in 1993 had resolved until appellant's pain was exacerbated by the work-related injury. He noted that the MRI scan performed after the 2013 injury mentioned appellant's previous history of low back conditions and appellant's subjective history of a back "discectomy." Based on the radiologist's findings, the hemi laminectomy was only to the remote right and there seemed to be further degeneration after the surgery. Therefore, Dr. Patel concluded that appellant's condition in 1993 that had warranted the surgery was minor and required only minor surgical intervention, which could have easily been worsened by the reported work injury.

In a September 14, 2018 development letter, OWCP informed appellant that additional medical evidence was necessary to establish the claimed consequential conditions. It advised her

that she should submit a rationalized medical opinion which provided a detailed history of injury and history of any preexisting condition, and a rationalized opinion regarding causal relationship between the June 7, 2013 traumatic event and her diagnosed conditions. OWCP afforded appellant 30 days to submit the necessary evidence.

In an August 7, 2018 report, Dr. Armstrong noted the history of appellant's work injury, her medical course, and the results of her October 3, 2013 lumbar MRI scan. He diagnosed clinical low back stain/sprain syndrome, diffuse degenerative disc disorder L4-5 and L5-S1 with right lateral recess with moderate-to-severe central stenosis at L4-5 and mild-to-moderate central canal stenosis and right lateral recess narrowing at L5-S1 with bilateral foraminal stenosis L5-S1 status post right L5-S1 hemi laminotomy. Dr. Armstrong opined that appellant had experienced temporary aggravation of low back pain from her lumbar degenerative disc disorder and that her back pain was caused by her lumbar strain/sprain. He noted that he would have to review an MRI scan which was taken prior to her surgical laminotomy to clarify antecedent degenerative disc changes and associated spondylosis with stenosis at the L3-4, L4-5, and L5-S1 levels. Dr. Armstrong further noted that without further review it would be speculation as to whether these conditions developed in the brief five-month period between the 2013 fall and the October 2013 MRI scan of the lumbar spine.

On May 7, 2019 OWCP expanded acceptance of the claim to include the conditions of right radial collateral ligament tear, right extensor tendon tear, right elbow ligament tear, and chronic lumbar sprain/strain.

By decision dated May 7, 2019, OWCP denied the expansion of the acceptance of appellant's claim to include the additional conditions of mild thickening of the right distal biceps tendon, diffuse degenerative disc disorder L4-5 and L5-S1, severe central canal stenosis at L4-5, mild-to-moderate central canal stenosis and right lateral recess narrowing at L5-S1, bilateral foraminal stenosis L5-S1, and lumbar degenerative disc disorder. It found that the medical evidence of record was speculative, equivocal and or insufficiently rationalized to establish causal relationship to the June 7, 2013 work injury.

On May 16, 2019 appellant, through counsel, requested an oral hearing before an OWCP hearing representative, which was held telephonically on August 19, 2019. By decision dated November 1, 2019, an OWCP hearing representative set aside OWCP's May 7, 2019 decision finding that the medical evidence raised an uncontroverted inference of causal relationship between the additional diagnosed medical conditions and the June 7, 2013 work injury and, therefore, was sufficient to warrant additional medical development of the claim. The hearing representative directed that OWCP issue an updated Statement of Accepted Facts (SOAF) and refer appellant to a second opinion examination with an appropriate medical specialist.

On remand OWCP referred appellant, along with a November 18, 2019 SOAF, a list of questions and the medical record, to Dr. John G. Keating, a Board-certified orthopedic surgeon, for a second opinion examination. In a December 16, 2019 report, Dr. Keating noted his review of the medical records and the SOAF. He related appellant's complaints, as well as her physical and radiographic examination findings and thereafter diagnosed sacroiliac joint arthrosis. Dr. Keating opined that appellant had residuals from her accepted work-related conditions and that the time missed from work was the result of the work-related accident and not an underlying

disease. He further opined that the work-related fall did not cause or contribute in any way to diffuse degenerative spinal disorder, severe spinal stenosis, right lateral recess narrowing, bilateral foraminal stenosis, and degenerative disc disease. Thus, Dr. Keating opined that no preexisting condition was accelerated or aggravated in any way by the work-related injury.

By decision dated April 3, 2020, OWCP denied expansion of the acceptance of appellant's claim to include the additional conditions of mild thickening of the right distal biceps tendon, diffuse degenerative disc disorder L4-5 and L5-S1, severe central canal stenosis at L4-5, mild-to-moderate central canal stenosis and right lateral recess narrowing at L5-S1, bilateral foraminal stenosis L5-S1 and lumbar degenerative disc disorder. It found that the medical evidence of record was insufficient to establish causal relationship of the medical conditions with regard to the June 7, 2013 work injury.

On April 15, 2020 appellant, through counsel requested an oral hearing before an OWCP hearing representative. Following a preliminary review, by decision dated May 22, 2020, an OWCP hearing representative found that the case was not in posture for a hearing as Dr. Keating's report required clarification as to whether the claimed conditions were present and, if so, whether there was any relationship between the June 7, 2013 work incident and any condition. Thus, the hearing representative vacated OWCP's April 3, 2020 decision and remanded the case for further development and issuance of a *de novo* decision regarding the request for claim expansion and any associated wage-loss compensation.

OWCP thereafter received January 15 and August 29, 2016 reports from Dr. Thien Quach, a Board-certified pain medicine specialist. In the August 29, 2016 report, Dr. Quach provided an assessment of spondylosis without myelopathy or radiculopathy.

On June 15, 2020 OWCP requested clarification from Dr. Keating and provided a June 22, 2020 updated SOAF. In a June 29, 2020 report, Dr. Keating indicated that appellant's work-related injury had caused or contributed to the conditions of diffuse degenerative spinal disorder at L4-5 and L5-S1, severe central canal spinal stenosis at L4-5, mild-to-moderate central canal stenosis, right lateral recess narrowing at L5-S1 and lumbar degenerative disc disorder, but opined that appellant was not suffering from the sequelae of those conditions. He opined that appellant had injured her sacroiliac joint in the June 7, 2013 work-related incident, which OWCP had accepted a lumbosacral strain/sprain condition.

On September 16, 2020 OWCP requested additional clarification from Dr. Keating. In an October 15, 2020 report, Dr. Keating opined that appellant's work-related injury did not exacerbate or cause the conditions of diffuse degenerative spinal disorder at L4-5 and L5-S1, severe central canal spinal stenosis at L4-5, mild-to-moderate central canal stenosis, right lateral recess narrowing at L5-S1 and lumbar degenerative disc disorder. He also opined that appellant's current lumbar spine condition was not the result of such conditions. Rather, Dr. Keating opined that appellant's current conditions were the result of a lumbosacral strain manifested in her sacroiliac joints, which was part of the accepted lumbosacral strain/sprain. He explained that appellant's second opinion examination was significant for sacroiliac joint instability and that her injury was a typical scenario for a lumbosacral injury.

On October 29, 2020 OWCP accepted the additional condition of sacroiliac joint instability.

By decision dated October 29, 2020, OWCP denied the expansion of the acceptance of appellant's claim to include the additional conditions of mild thickening of the right distal biceps tendon, diffuse degenerative disc disorder L4-5 and L5-S1, severe central canal stenosis at L4-5, mild-to-moderate central canal stenosis and right lateral recess narrowing at L5-S1, bilateral foraminal stenosis L5-S1, and lumbar degenerative disc disorder. It found that the weight of the medical evidence rested with the second opinion reports of Dr. Keating.

On February 22, 2021 appellant, through counsel, requested reconsideration.

In a February 13, 2021 report, Dr. Sami E. Moufawad, a Board-certified pain management specialist, noted that he had interviewed appellant and reviewed her medical records. Based on appellant's lumbar MRI scan findings, he found that appellant's diffuse degenerative disc disorder at L4-5 and L5-S1 resulting in several canal stenosis at L4-5, with mild-to-moderate central canal stenosis and right lateral recess narrowing at L5-S1, and bilateral foraminal stenosis at L5-S1 had preexisted the work injury since they were degenerative changes which took a few years to appear. Dr. Moufawad also found that the degenerative disc changes at L4-5 and L5-S1 noted on the MRI scan were chronic in nature and included the foraminal and canal stenosis. He indicated that after the June 7, 2013 work injury, the changes on the MRI scan became symptomatic. Dr. Moufawad explained that when appellant fell on June 7, 2013 the translational forces applied to the spine by her body weight led to deterioration of the equilibrium that existed between the degenerative changes in the disc and the supporting soft tissue structures, including the ligaments and muscles of the lumbar spine. He explained that when there was a traumatic incident like a fall, this led to acute trauma to the lumbar spine which disrupted the equilibrium between the soft tissues and the degenerative changes and appellant became symptomatic. Dr. Moufawad indicated that appellant developed two symptoms: lower back pain related to the degenerative changes; and pain down the right lower limb related to the lumbar stenosis. He medically explained that appellant did not reestablish the equilibrium with conservative therapy and developed chronic pain and radicular symptoms with radiation to the lower limb, resulting from neural foraminal stenosis or narrowing induced by the osteophytes and the degenerative changes seen on the MRI scan. Dr. Moufawad thus opined that the June 7, 2013 fall irreversibly and permanently accelerated the preexisting degenerative changes of the lumbar spine including degenerative disc disorder at L4-5, degenerative disc disorder at L5-S1, severe central canal stenosis at L4-5, mild-to-moderate central stenosis at L5-S1, right lateral recess narrowing at L5-S1, and bilateral foraminal stenosis at L5-S1.

By decision dated March 15, 2021, OWCP denied modification of its October 29, 2020 decision. It found that Dr. Moufawad's opinion was of lesser weight than Dr. Keating's opinion.

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.[4]

Causal relationship is a medical issue, and the medical evidence required to establish causal relationship is rationalized medical evidence.[5] 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.[6] 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.[7]

Section 8123(a) of FECA, which 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 (known as a referee physician or impartial medical specialist) who shall make an examination.[8] 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.[9] When there are opposing reports of virtually equal weight and rationale, and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[10]

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[4] *See L.C.*, Docket No. 20-0866 (issued February 26, 2021); *T.F.*, Docket No. 17-0645 (issued August 15, 2018); *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[5] *See S.L.*, Docket No. 19-0603 (issued January 28, 2020); *S.A.*, Docket No. 18-0399 (issued October 16, 2018); *Kenneth R. Love*, 50 ECAB 276 (1999).

[6] *See J.T.*, Docket No. 19-1723 (issued August 24, 2020); *P.M.*, Docket No. 18-0287 (issued October 11, 2018); *John W. Montoya*, 54 ECAB 306 (2003).

[7] *See H.T.*, Docket No. 20-1238 (issued July 12, 2021); *see also H.H.*, Docket No. 16-0897 (issued September 21, 2016); *James Mack*, 43 ECAB 321 (1991).

[8] 5 U.S.C. § 8123(a); *D.W.*, Docket No. 21-0840 (issued November 30, 2021); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009); *M.S.*, 58 ECAB 328 (2007).

[9] 20 C.F.R. § 10.321; *D.W.*, *id*; *R.C.*, 58 ECAB 238 (2006).

[10] *See M.C.*, Docket No. 20-1396 (issued November 22, 2021); *R.H.*, 59 ECAB 382 (2008); *James P. Roberts*, 31 ECAB 1010 (1980).

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met her burden of proof to establish that the acceptance of her claim should be expanded to include the additional condition of mild thickening of the right distal biceps tendon.

Appellant requested that OWCP expand the acceptance of her claim to include mild thickening of the right distal biceps tendon. In his December 2, 2013 report, Dr. Armstrong opined that typically there would be a hyperextension injury to the elbow in order to cause distal biceps tendon pathology, but appellant fell on a flexed right elbow, as she intentionally did not fall on an outstretched hand or wrist. As he negated causal relationship between the claimed distal biceps tendon condition and the work injury of June 7, 2013, his report is insufficient to establish appellant's claim.

The Board additionally finds that this case is not in posture for decision with regard to the acceptance of additional degenerative lumbar conditions including diffuse degenerative disc disorder L4-5 and L5-S1, severe central canal stenosis at L4-5, mild-to-moderate central canal stenosis and right lateral recess narrowing at L5-S1, bilateral foraminal stenosis L5-S1, and lumbar degenerative disc disorder.

Appellant also requested that OWCP accept additional lumbar conditions to include diffuse degenerative disc disorder L4-5 and L5-S1, severe central canal stenosis at L4-5, mild-to-moderate central canal stenosis and right lateral recess narrowing at L5-S1, bilateral foraminal stenosis L5-S1, and lumbar degenerative disc disorder. OWCP accepted lumbar conditions of chronic lumbar sprain/strain and sacroiliac joint instability. The Board notes that the record supports, and the medical evidence establishes, that the additional lumbar conditions of diffuse degenerative disc disorder L4-5 and L5-S1, severe central canal stenosis at L4-5, mild-to-moderate central canal stenosis and right lateral recess narrowing at L5-S1, bilateral foraminal stenosis L5-S1, and lumbar degenerative disc disorder are preexisting conditions. Thus, the issue is whether the June 7, 2013 work injury accelerated such conditions and whether such aggravation was permanent or temporary.

Dr. Moufawad noted the accepted lumbar conditions of chronic lumbar sprain/strain and sacroiliac joint instability and, based on MRI scan evidence, indicated that appellant had preexisting lumbar conditions. He provided a detailed history of injury, referenced objective medical reports demonstrating injury, and expressed, within a reasonable degree of medical certainty, his opinion on causal relationship, by providing a well-rationalized explanation detailing how appellant's preexisting and nonsymptomatic degenerative back conditions were precipitated or aggravated by the June 7, 2013 traumatic work-related injury and resulted in a permanent aggravation.

Dr. Keating, OWCP's second opinion physician and a Board-certified orthopedic surgeon, also noted that appellant had preexisting lumbar degenerative conditions. He opined that the work-related accident did not cause or contribute in any way to appellant's preexisting diffuse degenerative spinal disorder, severe spinal stenosis, right lateral recess narrowing, bilateral foraminal stenosis, and degenerative disc disease. Thus, Dr. Keating opined that none of those preexisting conditions were accelerated or aggravated in any way by the work-related injury.

Both Dr. Moufawad and Dr. Keating provided a description of appellant's June 7, 2013 employment injury and provided medical rationale for their respective findings regarding aggravation of appellant's preexisting lumbar conditions based on their review of the medical evidence and objective findings, which centered upon diagnostic testing. The Board, therefore, finds a conflict in medical opinion regarding whether appellant sustained a permanent or temporary aggravation of her preexisting lumbar conditions causally related to or as a consequence of her June 7, 2013 employment injury.[11] Under section 8123(a) of FECA, OWCP must resolve this conflict by referring appellant, together with the case record and a SOAF, to an impartial medical specialist.[12]

On remand OWCP shall refer appellant, along with the case file and a SOAF, to a specialist in the appropriate field of medicine for an impartial medical evaluation and a report including a rationalized opinion as to whether appellant's preexisting lumbar conditions are causally related to the accepted June 7, 2013 employment injury. Following this and other such development as OWCP deems necessary, it shall issue a *de novo* decision.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that the acceptance of her claim should be expanded to include mild thickening of the right distal biceps tendon. The Board further finds that the case is not in posture for decision regarding whether appellant has met her burden of proof to establish the acceptance of her claim to include additional preexisting lumbar conditions of diffuse degenerative disc disorder L4-5 and L5-S1, severe central canal stenosis at L4-5, mild-to-moderate central canal stenosis and right lateral recess narrowing at L5-S1, bilateral foraminal stenosis L5-S1, and lumbar degenerative disc disorder.

[11] *See D.H.*, Docket No. 19-0687 (issued March 31, 2021); *see also D.B.*, Docket No. 20-1142 (issued December 31, 2020).

[12] 5 U.S.C. § 8123(a); *see T.T.*, Docket No. 19-0544 (issued August 14, 2020).

ORDER

IT IS HEREBY ORDERED THAT the March 15, 2021 decision of the Office of Workers' Compensation Programs is affirmed in part, and set aside in part. The case is remanded to OWCP for further proceedings consistent with this decision of the Board.

Issued: December 1, 2022
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board