United States Department of Labor
Employees' Compensation Appeals Board

A.R., Appellant	)	
and	)	**Docket No. 19-1204**
	)	**Issued: February 25, 2021**
DEPARTMENT OF VETERANS AFFAIRS, FARGO VA HEALTH CARE SYSTEM, Fargo, ND, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 9, 2019 appellant filed a timely appeal from an April 3, 2019 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] 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] The Board notes that, following the April 3, 2019 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

[2] 5 U.S.C. § 8101 *et seq.*

ISSUES

The issues is whether appellant has met her burden of proof to expand the acceptance of the claim to include additional conditions, surgery, and related disability commencing August 7, 2015 causally related to her accepted April 20, 2015 employment injury.

FACTUAL HISTORY

On April 27, 2015 appellant, then a 51-year-old housekeeping aid, filed a traumatic injury claim (Form CA-1) alleging that on April 20, 2015 she twisted her right foot and ankle when she fell while in the performance of duty. OWCP accepted the claim for a right ankle sprain and paid appellant wage-loss compensation on the supplemental rolls from June 17 through July 11, 2015.

On April 23, 2015 Dr. John G. Mickelson, an osteopath and employing establishment physician, obtained a history of appellant sustaining an injury on April 20, 2015 when she slipped and fell. He noted that she was experiencing back pain and had previously received trigger point injections in her upper back. Dr. Mickelson diagnosed right foot pain, back and neck pain, and resolving elbow pain.

In a May 19, 2015 statement, appellant recounted that on April 20, 2015 she had twisted her right foot and had fallen on her back, striking her left elbow. She applied ice on her elbow and back following the incident.

On June 22, 2015 Dr. Bradley R. Olson, a podiatrist, performed a Brostrom repair of the right ankle.

In a treatment note dated June 29, 2015, Dr. Daniel Ostlie, a Board-certified surgeon, indicated that appellant had a postoperative fall on June 27, 2015. He noted that she had a history of ankle problems and diagnosed a right foot and ankle sprain/strain.

On July 13, 2015 appellant returned to full-time modified employment.

Dr. Mickelson noted on July 14, 2015 that appellant had resumed work following an April 20, 2015 employment injury. He diagnosed tendinitis of the left elbow, wrist, and forearm and advised that he was unsure whether it was related to the employment injury. On July 17, 2015 Dr. Mickelson obtained a history of appellant experiencing pain in her left arm extending to her wrist after folding laundry at work. He advised that she had lost strength in her arms and had also experienced numbness and tingling a few days earlier. Dr. Mickelson diagnosed right foot pain, left arm pain, transient intermittent weakness and paresthesia to her arms. He advised that he had consulted with appellant's supervisor about her work restrictions.

A July 22, 2015 magnetic resonance imaging (MRI) scan of the brain revealed moderate chronic brain atrophy, but no acute process. An MRI scan of the cervical spine showed moderate central canal stenosis and neural foraminal narrowing at C5-6 and C6-7 due to disc protrusions and spurring, mild central canal stenosis from disc protrusion at C4-5, and possible minimal cord edema. An MRI scan of the lumbar spine dated July 23, 2015 revealed mild degenerative disc disease at L3-4 and possibly L4-5. A computerized tomography (CT) scan obtained July 23, 2015 showed moderate degenerative disc findings at C5-6 and C6-7.

In a report dated July 23, 2015, Dr. Sneh N. Patel, who specializes in family medicine, obtained a history of appellant tripping and falling at work on April 20, 2015 landing on her left elbow, right hip, and right arm. He discussed her complaints of left elbow pain radiating into her neck, left leg spasm, headaches, unsteadiness, weakness, and lightheadedness. Dr. Patel diagnosed neuropathy and gait instability.

On July 24, 2015 Dr. Abdul A. Baker, a Board-certified neurosurgeon, performed an anterior cervical discectomy and decompression at C4-5, C5-6, and C6-7.

Appellant was admitted to the hospital for rehabilitation on July 29, 2015. In a July 30, 2015 hospital consultation, Dr. Steven Clemenson, a Board-certified internist, discussed appellant's history of slipping and falling on a wet floor at work on April 20, 2015, twisting her ankle, straining her neck, and hitting her left elbow. He diagnosed cervical radiculopathy after a fusion, muscle spasms, attention deficit disorder, anxiety disorder, fibromyalgia, and chronic anemia.

In an August 18, 2015 discharge summary, Dr. Bangalore Vijayalakshmi, a Board-certified physiatrist, diagnosed status post an April 20, 2015 employment injury, status post cervical myelopathy, and status post a July 24, 2015 cervical discectomy and decompression at C4-5, C5-6, and C6-7. She noted a history of appellant's symptoms having begun after she fell at work on April 20, 2015 striking her left elbow and injuring her back. Dr. Vijayalakshmi indicated that appellant had experienced numbness in her left arm moving into her right arm while performing modified employment, and that an MRI scan had showed disc protrusions and spurring at C5-6 and C6-7 causing moderate central canal stenosis and neuroforaminal stenosis treated with surgery on July 24, 2015. She advised that appellant had symptoms of cognitive impairment subsequent to her April 20, 2015 employment injury and that an MRI scan of the brain had revealed no acute process, but chronic moderate brain atrophy.

On August 20, 2015 Dr. Shaun K. Christenson, a Board-certified neurologist, evaluated appellant for recent facial pain. He noted that she reported cognitive dysfunction which she attributed to a fall. Dr. Christenson diagnosed chronic migraine and a history of right facial pain.

In a September 9, 2015 work capacity evaluation (Form OWCP-5c), Dr. Olson indicated that appellant was not working due to a neck injury. In a progress report of even date, he diagnosed left foot capsulitis that might require surgery in the future.

On September 16, 2015 Dr. Vijayalakshmi provided a history of appellant's April 20, 2015 employment injury and subsequent right ankle and cervical surgery. She advised that appellant had experienced cognitive deficits after her fall confirmed by a speech/language evaluation and had been recently discharged from an acute inpatient rehabilitation unit. Dr. Vijayalakshmi found that neurosurgery had determined that appellant was disabled from employment. She diagnosed left elbow and neck pain, gait ataxia, cervical myeloradiculopathy, a right ankle sprain post surgery, cervical surgery, and cognitive deficits after an April 20, 2015 injury. Dr. Vijayalakshmi opined that appellant's symptoms had "started as a result of her work injury on April 20, 2015."

On September 29, 2015 appellant filed a claim for compensation (Form CA-7) for disability for the period from August 7 to 29, 2015.

In a development letter dated October 13, 2015, OWCP informed appellant of the definition of a recurrence of disability and noted that it had not received medical evidence establishing that her cervical condition was causally related to her April 20, 2015 employment injury. It requested an opinion from a physician explaining how her disability resulted from her employment injury and provided a questionnaire for her completion. OWCP afforded appellant 30 days to submit the necessary information.

Thereafter, OWCP received an October 6, 2015 report from Dr. Olson, who discussed appellant's complaints of continued right foot and ankle problems. Dr. Olson found that she had multifactorial pain affecting the foot and ankle and diagnosed peroneal tendinitis of the right lower extremity, right tarsal tunnel syndrome, ankle instability, a right inversion sprain of the ankle, and a gait abnormality. He noted that there was "still some concern that appellant ruptured her repair after falling on it postoperatively."

In a report dated October 20, 2015, Dr. Paulina J. Kunecka, a Board-certified internist and neurologist, noted that her clinic had initially evaluated appellant in June 2014 for facial pain. She found that appellant had intermittent trigeminal neuralgia with no clear trigger. Dr. Kunecka diagnosed C2-3 neuropathy, right trigeminal neuralgia, migraine with aura, and chronic pain.

In an October 27, 2015 report, Dr. Gregory Hauge, a neuropsychologist, obtained a history of appellant experiencing cognitive problems after she fell on April 20, 2015 fall while mopping a floor. He diagnosed a possible concussion.

On October 30, 2015 Dr. Olson discussed appellant's history of bilateral ankle and foot problems and of falling after a Brostrom repair and possibly rupturing the repair. He diagnosed ankle instability, right foot pain, and right peroneal tendinitis.

On November 6, 2015 Dr. Vijayalakshmi described appellant's April 20, 2015 fall at work, her subsequent right ankle surgery and development of numbness of the left arm, wrist, and right upper extremity. She noted that appellant underwent an anterior discectomy and fusion at C4-5, C5-6, and C6-7 with instrumentation. Dr. Vijayalakshmi advised that appellant had cognitive difficulties after her fall. She opined that her April 20, 2015 fall "was the causation of all of her above-mentioned symptoms."

In a November 19, 2015 Form OWCP-5c, Dr. Olson found that appellant could perform sedentary employment.

By decision dated November 23, 2015, OWCP found that appellant had not established a recurrence of disability beginning July 17, 2015 causally related to her April 20, 2015 employment injury as she did not establish a material change/worsening of the accepted employment-related conditions.

Thereafter, OWCP received a November 19, 2015 report from Dr. Vijayalakshmi, who reviewed the history of appellant's April 20, 2015 employment injury and subsequent medical treatment. Dr. Vijayalakshmi described appellant's continued complaints of neck and upper back pain with radiculopathy particularly on the left, low back pain with radiculopathy, weakness of the upper and lower extremities, right foot pain and paresthesia, and cognitive deficits. She diagnosed status post fall causing right foot and ankle pain treated with surgery, neck and back pain with

bilateral upper and lower extremity pain and paresthesia, cervical spine surgery, left elbow pain, ongoing cognitive deficits, cervical myeloradiculopathy, and gait ataxia due to cervical myelopathy status post fall. Dr. Vijayalakshmi opined that the April 20, 2015 fall had caused all of appellant's symptoms and injuries.

On December 17, 2015 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

Subsequently, OWCP received a July 23, 2015 report from Dr. Baker, who advised that appellant had a history of multiple employment injuries. Dr. Baker evaluated her for an acute onset of numbness, tingling, and weakness in the left upper extremity. He obtained diagnostic studies and recommended a cervical discectomy and fusion from C4 to C7.

In a July 28, 2015 hospital consultation report, Dr. Vijayalakshmi evaluated appellant to determine whether she required admission for rehabilitation. She provided the history of the April 20, 2015 slip and fall and reviewed the diagnostic studies of record. Dr. Vijayalakshmi diagnosed status post cervical discectomy and fusion and cervical myeloradiculopathy and obtained a history of appellant's symptoms beginning after an April 20, 2015 employment injury. She recommended rehabilitation at the inpatient unit.

On July 29, 2015 Dr. Kunecka noted that appellant had fallen at work onto her left arm and elbow the second week of July and subsequently experienced numbness and left arm pain. Following cervical surgery, appellant had ataxia and difficulty ambulating. Dr. Kunecka noted that appellant had also fallen in April 2015 injuring her right lateral ankle. She attributed appellant's ataxia to her cervical spine disease as she was in the postoperative period.

In a February 9, 2016 progress report, Dr. Vijayalakshmi reviewed the history of the April 20, 2015 employment injury. She diagnosed pain in the neck and back with bilateral upper and lower pain, paresthesia, and weakness, right foot and ankle pain, status post right ankle and cervical spine surgery, bilateral elbow pain, cognitive deficits, gait ataxia, myofascial pain and dysfunction syndrome, and lumbar spine degenerative disc disease and attributed the diagnosed conditions to appellant's fall.

An electromyogram performed by Dr. Vijayalakshmi on March 7, 2016 revealed slowing of the left ulnar motor nerve across the elbow.[3]

In a March 29, 2016 form report, Dr. Emmet J. Kenney, Jr., a Board-certified psychiatrist, diagnosed affective disorder and anxiety-related disorder. He advised that, prior to the injury, appellant had abnormal attention span and impulse control, but had been able to work until she was injured on the job. Dr. Kenney opined that appellant was unable to work and noted that pain affected her ability to perform activities of daily living.

[3] Dr. Vijayalakshmi, in an April 6, 2016 progress report, diagnosed low back pain, myofascial pain syndrome, lumbar degenerative disc disease and musculoligamentous sprain/strain, and to rule out lumbar radiculopathy, peripheral neuropathy, and entrapment syndrome.

On April 7, 2016 Dr. David Beard, a Board-certified orthopedic surgeon, evaluated appellant for left elbow pain after a fall at work on April 20, 2015. He diagnosed left elbow pain and a history of a fall.

On April 29, 2016 OWCP requested that Dr. Michael M. Katz, a Board-certified orthopedic surgeon serving as a district medical adviser (DMA), review the evidence and address whether appellant's anterior discectomy and fusion at C4-5, C5-6, and C6-7 was necessary to treat the effects of her April 20, 2015 employment injury and whether it should expand acceptance of her claim to include the additional conditions of cervical myelopathy with cord compression and cervical instability at C4-5 and left ulnar neuropathy.

In a May 5, 2016 report, Dr. Katz advised that Dr. Mickelson's reports failed to support that appellant had sustained multiple trauma as found by Dr. Vijayalakshmi. He opined that additional diagnoses and the July 24, 2015 spinal surgery were unrelated to the April 20, 2015 employment injury.

In a May 12, 2016 progress report, Dr. Vijayalakshmi indicated that appellant had multiple syndromes after an April 20, 2015 employment injury. She advised that the injury had caused "cervical instability for which she underwent cervical spinal surgery, injuries to her bilateral elbows, worse on the left than the right, low back pain as well as lower limb symptoms in addition to her bilateral ankle and feet pain/injuries." Dr. Vijayalakshmi diagnosed employment-related cervical spine instability postsurgery, left more than right bilateral elbow pain, bilateral foot and ankle pain, pain in the neck, upper, and middle back, left cubital tunnel syndrome and ulnar neuropathy, and status post ankle surgery. She also diagnosed sacroiliac (SI) joint dysfunction, myofascial pain and dysfunction syndrome, lumbar degenerative disc disease and a musculoligamentous sprain/strain, and cervicothoracic musculoligamentous sprain/strain. On June 20, 2016 Dr. Vijayalakshmi advised that she was treating appellant for "symptoms status post work injury of April 20, 2015." She provided the same diagnoses.

In a July 5, 2016 progress report, Dr. Vijayalakshmi discussed appellant's complaints of worsening neck and upper and middle back pain. She diagnosed neck, upper and middle back pain and intermittent bilateral upper extremity pain and paresthesia, slowing of the left ulnar motor nerve velocity at the elbow, left elbow pain and low back pain after an April 20, 2015 employment injury, SI joint dysfunction, myofascial pain and dysfunction syndrome, cervicothoracic musculoligamentous sprain/strain, and ongoing cognitive deficits. Dr. Vijayalakshmi found that appellant was unable to work and recommended that she seek disability from the Social Security Administration (SSA).

A hearing was held on August 16, 2016. Counsel asserted that appellant had sustained an injury to her cervical spine as a result of the April 20, 2015 employment injury. He advised that appellant had not fallen in July 2015 as reported by a physician, noting that the date appeared to be a transcription error. Appellant related that when she resumed work on July 13, 2015 sorting and folding towels she had experienced left elbow pain and weakness moving into her neck.

On July 19, 2016 David J. Hanson, an anesthesiologist, diagnosed chronic cervicogenic headache, cervical myofascial pain syndrome, and lumbago.

By decision dated October 13, 2016, OWCP's hearing representative affirmed the November 23, 2015 decision.

On July 7, 2017 Dr. Vijayalakshmi advised that appellant was waiting for federal workers' compensation to approve, as related to the employment injury, neck pain with bilateral upper extremity pain and paresthesia, low back pain with lower limb symptoms, upper and middle back pain, and cognitive deficits. She noted that appellant was also pursuing disability compensation from SSA.

On October 6, 2017 OWCP advised Dr. Vijayalakshmi that it had accepted only a right ankle sprain as employment related. It requested that she address whether the current diagnosed conditions were causally related to the accepted employment injury and whether appellant required work restrictions due to her accepted employment injury.

On October 11, 2017 counsel requested reconsideration. He submitted a September 7, 2017 report by Dr. Baker. Dr. Baker diagnosed cervical instability at C4-5 and a cord injury with stenosis at C5-6 and C6-7, left ulnar neuropathy/elbow pain, and SI joint dysfunction due to the April 20, 2015 fall at work.

By decision dated January 9, 2018, OWCP denied modification of its October 13, 2016 decision.

Thereafter, OWCP received a November 3, 2016 report from Dr. Baker. Dr. Baker noted that appellant "underwent anterior cervical fusion over a year ago secondary to [a] work-related injury and spinal cord injury due to work." He discussed her complaints of continued upper extremity numbness and tingling on the left side with S1 joint dysfunction. Dr. Baker advised that appellant's "fall occurred at work, which involved both involvement of her neck and SI joint." He found that she was "status post anterior cervical fusion and spinal cord compression due to [a] work-related injury and SI joint instability probably secondary to the fall because she was asymptomatic prior to that event." Dr. Baker recommended a left SI joint fusion.

In a treating physician medical opinion statement form dated November 26, 2016, Dr. Vijayalakshmi diagnosed fibromyalgia, chronic pain syndrome, and myofascial pain and opined that appellant was disabled from employment. She provided the date of onset as April 20, 2015.

On January 8, 2019 appellant requested reconsideration. She advised that she had sustained a neck injury due to her April 20, 2015 employment injury, but it was not diagnosed until July 2015. Appellant maintained that she was unable to work either at the employing establishment or in the private employment that she concurrently held at the time of her accident.

By decision dated April 3, 2019, OWCP denied modification of its January 9, 2018 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[4] has the burden of proof to establish the essential elements of his or her claim by the weight of the evidence.[5] 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]

Under FECA, the term disability means an incapacity because of an employment injury, to earn the wages the employee was receiving at the time of the injury.[7] For each period of disability claimed, the employee has the burden of proof to establish that he or she was disabled from work as a result of the accepted employment injury.[8] Whether a particular injury causes an employee to become disabled from work, and the duration of that disability, are medical issues that must be proven by a preponderance of probative and reliable medical opinion evidence.[9] For each period of disability claimed, the employee has the burden of proof to establish that he or she was disabled from work as a result of the accepted employment injury.[10]

The medical evidence required to establish causal relationship is rationalized medical opinion evidence. 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 claimed disability and the accepted employment injury.[11]

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, OWCP shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[12] This is called a referee examination and OWCP will select a

[4] *Supra* note 2.

[5] *Y.D.*, Docket No. 20-0097 (issued August 25, 2020); *D.P.*, Docket No. 18-1439 (issued April 30, 2020); *Amelia S. Jefferson*, 57 ECAB 183 (2005).

[6] *K.T.*, Docket No. 19-1718 (issued April 7, 2020); *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[7] 20 C.F.R. §10.5(f); *see J.T.*, Docket No. 19-1813 (issued April 14, 2020); *Cheryl L. Decavitch*, 50 ECAB 397 (1999).

[8] *Id.*; *Fereidoon Kharabi*, 52 ECAB 291, 293 (2001).

[9] 20 C.F.R. § 10.5(f); *J.M.*, Docket No. 18-0763 (issued April 29, 2020).

[10] *Id.*

[11] *E.M.*, Docket No. 18-1599 (issued March 7, 2019); *Robert G. Morris*, 48 ECAB 238 (1996); *see also T.T.*, Docket No. 18-1054 (issued April 8, 2020).

[12] 5 U.S.C. § 8123(a); *L.S.*, Docket No. 19-1730 (issued August 26, 2020); *M.S.*, 58 ECAB 328 (2007).

physician who is qualified in the appropriate specialty and who has no prior connection with the case.[13]

ANALYSIS

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

In support of her request for claim expansion, appellant submitted reports dated August 18, 2015 to July 7, 2017 from Dr. Vijayalakshmi. In a September 16, 2015 progress report, Dr. Vijayalakshmi indicated that appellant had injured her neck when she fell on April 20, 2015 and had also experienced cognitive defects following her injury. She diagnosed left elbow and neck pain, gait ataxia, cervical myeloradiculopathy, a right ankle sprain, cervical surgery, and cognitive defects. Dr. Vijayalakshmi attributed the diagnosed conditions to the accepted employment injury. On November 19, 2015 she diagnosed bilateral upper and lower extremity pain and paresthesia, cervical spine surgery, ongoing cognitive deficits, cervical myeloradiculopathy, and gait ataxia due to the April 20, 2015 employment injury. In a May 12, 2016 progress report, Dr. Vijayalakshmi related that the accepted employment injury had caused cervical instability requiring surgery and also injuries to the bilateral elbows and low back. She diagnosed cervical spine stability post surgery, left more than right bilateral elbow pain, bilateral foot and ankle pain, pain in the neck, upper, and middle back, left cubital tunnel syndrome and ulnar neuropathy, and status post ankle surgery and attributed the conditions to the April 20, 2015 employment injury.

In a May 5, 2016 report, Dr. Katz advised that Dr. Mickelson's reports failed to support that appellant had sustained multiple trauma as found by Dr. Vijayalakshmi. He opined that additional diagnoses and the July 24, 2015 spinal surgery were unrelated to the April 20, 2015 employment injury.

As noted above, if there is a disagreement between an employee's physician and an OWCP referral physician, OWCP will appoint an impartial medical specialist who shall make an examination.[14] The Board finds that a conflict exists between the appellant's treating physician, Dr. Vijayalakshmi and the DMA, Dr. Katz regarding whether the claim should be expanded to include additional conditions, surgery, and related disability commencing August 7, 2015 causally related to her accepted April 20, 2015 employment injury.

Therefore, the case must be remanded to OWCP for referral of appellant to an impartial medical specialist for resolution of the conflict in medical opinion evidence in accordance with 5 U.S.C. § 8123(a).[15] The issue of whether the acceptance of appellant's claim should be expanded to include additional conditions must be resolved prior to determining whether appellant has met her burden of proof to establish that she was disabled from work commencing August 7, 2015 causally related to her accepted April 20, 2015 employment injury and resultant surgery. After

[13] 20 C.F.R. § 10.321; *P.B.*, Docket No. 20-0984 (issued November 25, 2020); *R.C.*, 58 ECAB 238 (2006).

[14] *See S.S.*, Docket No. 19-1658 (issued November 12, 2020); *C.S.*, Docket No. 19-0731 (issued August 22, 2019).

[15] *S.M.*, Docket No. 19-0397 (issued August 7, 2019).

this and other such further development as OWCP deems necessary, it shall issue *a de novo* decision.

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the April 3, 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: February 25, 2021
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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