U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of DARRELL M. RHOADES and SMITHSONIAN INSTITUTION, NATIONAL GALLERY OF ART, Washington, D.C.

Docket No. 96-2645; Submitted on the Record;
Issued November 20, 1998

DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON, MICHAEL E. GROOM

The issue is whether appellant has established that he had continuing disability after July 21, 1995 causally related to his June 26, 1992 employment-related lumbar strain.

In the present case, the Office of Workers' Compensation Programs has accepted that appellant, a security officer, sustained a lumbar strain on June 26, 1992. Appellant explained his injury as occurring when his back "went out" while he got up out of a chair and took a step to the right. The Office also accepted that appellant sustained a recurrence of disability causally related to the accepted June 26, 1992 injury on September 24, 1994. Appellant intermittently missed periods of work after September 24, 1994 and filed forms CA-8 claiming periods of continuing disability. By decisions dated June 24 and July 29, 1996, the Office denied payment of continuing benefits on the grounds that the medical evidence of record failed to establish that appellant continued to suffer residual disability after July 21, 1995 causally related to the accepted injury.

The Board has duly reviewed the case record and finds that appellant has not met his burden of proof in this case.

The Board has previously held that where the Office pays compensation based upon submission of forms CA-8 following a claimant's return to work, the claimant maintains the burden of submitting medical evidence establishing entitlement to continuing disability which was related to the employment injury.[1]

The medical evidence establishes that appellant's treating physician, Dr. H.S. Pabla, a Board-certified orthopedic surgeon, recommended that appellant undergo a magnetic resonance imaging (MRI) scan of the lumbar spine in November 1994, following appellant's recurrence of disability, to rule out discogenic lumbar radiculopathy. Appellant underwent the MRI scan on

[1] *Donald Leroy Ballard*, 43 ECAB 876 (1992).

November 8, 1994 which was interpreted by Dr. Pabla as revealing a mild, bulging disc at L4-5 with degenerative disc disease, and no spinal canal stenosis. A computerized tomography (CT) examination was then performed on February 2, 1995 which was interpreted by Dr. Pabla as revealing a bulging, herniated disc at L4-5, with compression of the thecal sac resulting in spinal stenosis and probably a hairline fracture, transverse process of the L5 vertebra.

Dr. Pabla referred appellant to Dr. Lawrence Fink, Board-certified in neurological surgery. In a report dated March 10, 1995 Dr. Fink stated that appellant's various radiographic studies showed spina bifida occulta and partial sacralization of L5. He also stated that appellant's lumbar MRI of November 8, 1994 showed only minimal annular bulging at L4-5 with mild degenerative changes at that level, and that his lumbar CT scan of February 2, 1995 suggested possible protrusion of the L4-5 intervertebral disc. Dr. Fink concluded that appellant's clinical picture and radiographic studies were at variance and that his discrepancy required resolution. He recommended that appellant be referred for repeat MRI scanning or lumbar CT/myelography. Dr. Fink concluded that depending upon the results of additional studies, surgical intervention may be considered, or with a negative study appellant could return to work without significant restriction. On March 22, 1995 Dr. Pabla noted that appellant's previous MRI scan showed a bulging disc at L5-S1 and no evidence of spinal stenosis. He also noted that there was a discrepancy, however, between appellant's clinical findings and radiographic changes. Dr. Pabla therefore recommended that appellant undergo a high resolution MRI scan.

On April 5, 1995 Dr. Pabla reported that appellant's MRI scan performed on March 28, 1995 revealed a mild bulging disc at L4-5, and no change since the previous study. On April 19, 1995 Dr. Pabla diagnosed appellant's condition as lower back pain syndrome, again noting the findings of the MRI scan performed on March 28, 1995. Dr. Pabla did not, however, offer a medical opinion causally relating the bulging disc found on MRI examination or appellant's diagnosis of low back pain syndrome to the accepted injury. While both Dr. Pabla and Dr. Fink attempted through various x-ray and MRI studies to define the exact nature of appellant's lumbar condition following November 1994, they did not explain how appellant's 1992 employment injury, which was accepted for lumbar strain, would have caused or contributed to the subsequent conditions. Appellant has the burden of establishing by the weight of the reliable, probative and substantial evidence that his condition was caused or adversely affected b his employment. As part of this burden he must present rationalized medical opinion evidence, based on a complete factual and medical background, showing causal relation.[2] Neither Dr. Pabla nor Dr. Fink offered any rationalized medical opinion regarding the cause of appellant's condition after November 1994.

The Office thereafter referred appellant to Dr. David C. Johnson, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a report dated April 27, 1995, Dr. Johnson noted that there was a discrepancy between appellant's MRI scan performed in 1992 and a CT scan performed in 1995. He noted that the discrepancy might have arisen from the fact that appellant had six lumbar vertebrae with a hemisacrilization, which may have led to a specific level not being appropriately designated. He also noted that appellant's

[2] *Kimper Lee*, 45 ECAB 565 (1994).

electromyography (EMG) studies suggested spinal stenosis and that appellant's initial MRI scan suggested spinal stenosis of a congenital nature. Dr. Johnson explained that lumbar stenosis frequently produced pain in the lower extremities with prolonged standing and walking as well as sitting and that these were the symptoms that appellant currently experienced. Dr. Johnson stated that he therefore felt that appellant's symptoms were most likely related to a lumbar stenosis superimposed on degenerative disc disease, further compromising the canal and producing symptoms. Regarding appellant's employment injury, Dr. Johnson stated that it was likely that appellant had a lumbar strain from the 1992 injury, but no specific injury in 1994. He stated that appellant had improved from the 1992 injury to the point where he was asymptomatic. Dr. Johnson concluded that appellant's preexisting condition was responsible for his current symptoms and that appellant no longer had any residual of his June 1992 injury. Finally, he noted that while appellant may have developed a bulging disc in 1994 further narrowing the canal and producing his current symptoms, the record did not confirm that an actual work-related injury occurred in 1994.[3] Dr. Johnson properly reviewed appellant's history of injury and medical treatment and thereafter concluded that appellant's 1992 lumbar strain had resolved. Dr. Johnson noted that appellant's condition changed in 1994, however, no work-related event was responsible. Dr. Johnson concluded that appellant had a preexisting lumbar condition which was the cause of his current symptoms. As Dr. Johnson did offer an rationalized opinion regarding the cause of appellant's current condition, his opinion is of probative medical value.[4]

On June 6, 1995 appellant was evaluated by Dr. Najmaldin O. Karim, a Board-certified neurosurgeon. In a report dated June 6, 1995, Dr. Karim stated that appellant had undergone EMG and nerve condition studies in 1992 which were abnormal. Dr. Karim stated that appellant had undergone three MRI scans, the last on March 28, 1995, which showed mild disc bulging at L4-5, with no disc herniation; and that his November 1994 MRI scan essentially showed the same finding. He noted that a CT scan of the lumbar spine showed bulging disc at L4-5 and plain x-rays showed a level with lumbarized first sacral segment and spina bifida occulta at the lumbosacral junction. Dr. Karim concluded that appellant "most likely" had sustained a lumbar strain and that he had a mild bulging disc, with no nerve root compression and no spinal stenosis. Dr. Karim stated that he did not recommend surgical intervention and that appellant would return to Dr. Pabla for continued care.

Finally, appellant again underwent MRI evaluation of the cervical and lumbar spine on May 10, 1996, conducted by Dr. Philip Man, a Board-certified diagnostic radiologist. Dr. Man reported that the MRI of the lumbar spine showed a sacralized L5 and small central posterio disc herniation at L4-5, without significant lateralization. Dr. Man noted that the significance of the findings would have to be correlated clinically and offered no opinion regarding the cause of appellant's lumbar condition.

As Dr. Karim and Dr. Man attempted to diagnose appellant's condition but did not provide any medical opinion as to whether appellant's condition was causally related to his

[3] The Board notes that Dr. Johnson was a second opinion physician, not an impartial medical specialist.

[4] *Lourdes Harris*, 45 ECAB 545 (1994).

accepted employment injury, their opinions are of limited probative value regarding the issue of causal relationship.

Appellant did not submit the necessary rationalized medical evidence which explained why his condition following November 1994 was causally related to his accepted June 26, 1992 lumbar strain. The Office therefore properly determined that appellant had not met his burden of proof.

The decisions of the Office of Workers' Compensation Programs dated July 29 and June 24, 1996 are hereby affirmed.

Dated, Washington, D.C.
November 20, 1998

Michael J. Walsh
Chairman

David S. Gerson
Member

Michael E. Groom
Alternate Member