United States Department of Labor
Employees' Compensation Appeals Board

L.G., Appellant	)	
and	)	**Docket No. 11-1174**
	)	**Issued: June 6, 2012**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Dallas, TX, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 14, 2011 appellant filed a timely appeal from a March 28, 2011 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.

ISSUES

The issues are: (1) whether appellant met his burden of proof to establish that he was disabled beginning January 20, 2011 as a result of his accepted back conditions; and (2) whether OWCP properly denied authorization for his back surgery.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On May 5, 1995 appellant, then a 41-year-old automation clerk, filed a traumatic injury claim alleging that on June 10, 1994 he experienced lower back pain when he swept down the optical character reader and moved trays. OWCP accepted his claim for a lumbar sprain and eventually for degenerative disc disease.[2] Appellant received disability compensation and returned to modified duty in 1995. He has received continued medical treatment for the accepted conditions from the date of injury through the current time.

Based on a March 11, 2010 electrodiagnostic report, Dr. Stephen J. Becker, Board-certified in physical medicine and rehabilitation, stated that on June 10, 1994 appellant sustained a job-related injury and continued to complain of lumbar pain, numbness and tingling and increased weakness in his lower extremities. Upon examination, he observed cervical flexion within normal limits, extension decreased by 50 percent and rotation to the left decreased by 20 percent. Dr. Becker diagnosed bilateral L5-S1 lumbar radiculopathy with bilateral L5 and S1 root slowing at the spinal level and possible concurrent cervical disc disease with bladder dysfunction.

In a June 29, 2010 lumbar spine x-ray report, Dr. H. Stuart Peake, a diagnostic radiologist, observed normal vertebral body alignment with minimal disc interval thinning at L5-S1 and intact posterior elements. He found no subluxation at any level, no abnormality with flexion and extension views and no evidence of fracture.

Dr. Bryce I. Benbow, an orthopedic surgeon, noted in his June 29, 2010 report that appellant's back pain started in 1994 when he was injured at work. He reviewed previous medical reports and found disc narrowing and posterior fissuring at L5-S1, worse on the right than the left and bilateral L5-S1 lumbar radiculopathy with bilateral L5 and S1 root slowing at appellant's spinal level. Dr. Benbow diagnosed lumbosacral disc degeneration and sprain of lumbar region.

A magnetic resonance imaging (MRI) scan report was reviewed by Dr. Crys Sory, a diagnostic radiologist, and in his July 13, 2010 report, observed normal appearance with no intraspinal tumor or mass present and normal vertebral bodies heights, general marrow signal and anterior paravertebral soft tissues in appellant's spine. He found 1.9 millimeter (mm) central disc protrusion at L4-5, dehydration with narrowing in the L5-S1 disc and a 1 mm disc bulge producing minimal flattening of the thecal sac. Otherwise, Dr. Sory also noted that appellant's lumbar spine results were negative.

In a September 16, 2010 report, Dr. Benbow noted appellant's complaints of back and leg symptoms. Upon examination of the lumbar spine, he noted limited range of motion with forward flexion and decreased sensory along the right anterior thigh, lateral shin and dorsum of the foot and lateral foot. Appellant's straight leg and Lasegue's tests were also positive bilaterally. Dr. Benbow diagnosed lumbosacral disc degeneration and lumbar region sprain. Based on the progression of appellant's pain and ongoing debilitating nature, he recommended a spinal fusion surgery at the L5-S1 level. Dr. Benbow pointed out that appellant had limited

[2] OWCP also accepted a January 19, 1995 recurrence claim and a February 7, 2003 recurrence of disability claim.

response to extensive physical therapy, work hardening, injections and medication and referred appellant for a second opinion.

Dr. Benbow further examined appellant on October 14, 2010 and noted complaints of back and leg pain with all ranges of motion. He observed tenderness to palpation in the paraspinuous region over L5-S1 and a bilateral sciatic notch and posterior thigh tenderness to palpation in appellant's lumbar spine. Appellant's straight leg raising test and Lasegue's test were positive bilaterally. Dr. Benbow also noted decreased sensation along the right anterior and lateral thigh, lateral and medial shin and the dorsum and sole of appellant's right foot. He diagnosed lumbosacral disc degeneration and sprain of lumbar region and noted that he was waiting for a second opinion from another spinal surgeon before requesting surgery.

In an October 18, 2010 report, Dr. Sherine Reno, Board-certified in physical medicine and rehabilitation, noted that Dr. Benbow evaluated appellant and was considering surgery. She diagnosed lumbar disc injury with disrupted disc syndrome and some evidence of radicular symptoms.

Dr. Benbow referred appellant to Dr. Michael Rimlawi, an orthopedic surgeon, for an opinion regarding appellant's L5-S1 spinal fusion. Dr. Rimlawi provided, in his October 21, 2010 report, an accurate history of injury and reviewed appellant's medical history. MRI scans revealed disc space collapse, disc desiccation at L5-S1 and disc herniation at L5-S1 on the right side with some right-sided foraminal narrowing and right subarticular recess stenosis. Electromyography revealed appellant had right L5-S1 radiculopathy. Upon examination, Dr. Rimlawi observed decreased sensation in the entire right lateral aspect of appellant's right leg and foot, trochanteric bursa tenderness bilaterally, positive sacroiliac joint tenderness and pain to percussion on his lumbar spine. Appellant's straight leg raise test was positive bilaterally. Dr. Rimlawi diagnosed disc herniation L5-S1, right lower extremity radiculopathy, low back pain and internal disc disruption. He noted that appellant went through various conservative treatment measures but still experienced lumbar pain. Dr. Rimlawi reviewed various treatment options with appellant, both surgery and nonsurgery related and stated that appellant wanted to proceed with surgery. He concluded that "an L5-S1 fusion surgery [was] warranted for this patient."

In a November 4, 2010 report, Dr. Benbow noted that appellant needed to be scheduled for surgery as quickly as possible and that he was unable to work at all. He opined that appellant was an excellent candidate for an anterior interbody fusion at L5-S1 fusion due to his severe loss of disc height and degenerative disc at the L5-S1 level. Dr. Benbow submitted that request for surgery to OWCP on November 16, 2010

On November 19, 2010 OWCP advised appellant that his request for back surgery was needed to be reviewed by a district medical adviser (DMA) prior to a determination.

In a December 9, 2010 report, Dr. Benbow noted the surgery authorization was still pending with OWCP and noted appellant's complaints of severe pain with standing, walking or sitting for prolonged periods and increased pain radiating to the right leg. Examination of appellant's lumbar spine revealed severe pain with limited range of motion of 15 to 20 degrees flexion, 5 degrees extension and 5 to 10 degrees rotation and side bending. Dr. Benbow also

observed paraspinous tenderness around the lower lumbar segments and right gluteal notch tenderness. He diagnosed lumbosacral disc degeneration and sprain of lumbar region.

Dr. Michael M. Katz, an OWCP medical adviser, reviewed the medical record and in a January 4, 2011 report concluded that a second-opinion evaluation by a Board-certified neurosurgeon or orthopedic surgeon was necessary to determine if OWCP should authorize the recommended back surgery. He stated that "the degree of objective pathology including MRI scan and electrodiagnostics does not clearly correlate with the degree of subjective complaints and physical findings or the extent of the proposed surgery."

In a January 6, 2011 report, Dr. Benbow continued to note tenderness to palpation in the paraspinous lumbar region from L4 to S1, gluteal pain bilaterally and right sciatic-notch pain. He diagnosed lumbosacral disc degeneration and sprain of lumbar region.

On February 4, 2011 appellant filed a claim for disability compensation beginning January 20, 2011.[3]

In letters dated February 28 and March 8, 2011, OWCP advised appellant that additional evidence was needed regarding his claim for disability compensation and requested additional medical evidence establishing that he was disabled from work during the entire period claimed as a result of his accepted conditions.

In a February 15, 2011 report, Dr. Benbow noted appellant's continued complaints of severe back and leg pain and sleepless nights. Upon examination, he noted that appellant's lumbar spine had severe tenderness to palpation in the paraspinous region bilaterally and gluteal pain worse on the right than on the left. Appellant's straight leg raise test was positive bilaterally, worse on the right than the left. Dr. Benbow diagnosed lumbosacral disc degeneration and lumbar region sprain. He also provided an attending physician's report where he noted that appellant was disabled from September 17, 2010 to May 15, 2011.

Dr. Marvin Van Hal, a second-opinion Board-certified orthopedic surgeon, reviewed the statement of facts and provided an accurate history of injury. On examination, he observed decreased sensation in appellant's bilateral thighs, tenderness over the trochanteric area and positive results for Waddell testing, straight leg raise test and rotation simulation. Appellant was unable to perform lumbar range of motion due to discomfort. Dr. Van Hal, in his February 22, 2011 report, diagnosed low back sprain with pain of the lumbosacral spine and radicular symptoms but without distinct radicular findings. Regarding the lumbar surgery, he opined that appellant had symptoms greater than the findings on his assessment and explained that lumbar spinal fusion surgery for a patient who did not have spine instability or a fracture was not fully supported by medical evidence. Thus, Dr. Van Hal concluded "within reasonable probability and evidence based medicine" that there was no medical necessity for the proposed surgical intervention for appellant's lumbar condition. He explained that appellant's inability to perform even the relatively modest activity in the office of walking, bending and flexing was so marginal

[3] Appellant filed three different disability compensation claim forms for the periods January 20 to 29, 2011; February 1 to 12, 2011; and February 15 to 26, 2011.

that no surgery would be likely to offer any benefit to him. Dr. Van Hal also provided a February 23, 2011 functional capacity evaluation report.

On March 8, 2011 OWCP forwarded Dr. Van Hal's report to Dr. Benbow for comment. No response was received.

In a decision dated March 28, 2011, OWCP denied appellant's claim for disability compensation beginning January 20, 2011 finding that he failed to provide probative medical evidence supporting total disability from work for the entire claimed period. It also denied authorization for him to undergo anterior lumbar interbody fusion surgery with posterior decompression and instrumentation at L5/S1. Relying on Dr. Van Hal's February 22, 2011 second-opinion evaluation, OWCP determined that the surgical procedures were not medically necessary for appellant's spine disorder.

LEGAL PRECEDENT -- ISSUE 1

The term disability as used in FECA means the incapacity because of an employment injury to earn wages that the employee was receiving at the time of injury.[4] Disability is thus, not synonymous with physical impairment, which may or may not result in an incapacity to earn wages.[5] For each period of disability claimed, the employee has the burden of establishing that he or she was disabled for work as a result of the accepted employment injury.[6] Whether a particular injury causes an employee to be disabled for employment is a medical issue which must be proven by a preponderance of the reliable, probative and substantial medical evidence.[7] Findings on examination are generally needed to support a physician's opinion that an employee is disabled for work.[8] The Board will not require OWCP to pay compensation for disability in the absence of any medical evidence addressing the specific dates of disability for which compensation is claimed. To do so would essentially allow employees to self-certify their disability and entitlement to compensation.[9]

ANALYSIS -- ISSUE 1

OWCP accepted appellant's June 10, 1994 traumatic injury claim for a lumbar sprain and degenerative disc disease. Appellant returned to modified work after the injury and sought continued medical treatment for the accepted conditions. He requested disability compensation beginning January 20, 2011. OWCP denied appellant's claim finding insufficient medical evidence to establish that he was disabled from work during the claimed period due to his

[4] 20 C.F.R. § 10.5(f); *Paul E. Thams*, 56 ECAB 503 (2005).

[5] *See Fred Foster*, 1 ECAB 21 (1947).

[6] *Sandra D. Pruitt*, 57 ECAB 126 (2005); *Dennis J. Balogh*, 52 ECAB 232 (2001).

[7] *G.T.*, 59 ECAB 447 (2008); *Gary J. Watling*, 52 ECAB 278 (2001).

[8] *See S.F.*, 59 ECAB 525 (2008); *Fereidoon Kharabi*, 52 ECAB 291 (2001).

[9] *Amelia S. Jefferson*, 57 ECAB 183 (2005); *see William A. Archer*, 55 ECAB 674 (2004).

accepted conditions. The Board finds that he did not provide sufficient medical evidence to establish his claim for work-related disability beginning on January 20, 2011.

The only medical evidence appellant submitted to support his claim for disability compensation for the period in question was Dr. Benbow's February 15, 2011 report. Dr. Benbow noted appellant's complaints of severe back and leg pain, conducted an examination and diagnosed lumbosacral disc degeneration and lumbar region sprain. He indicated in his attending physician's report that appellant was disabled from September 17, 2010 to May 15, 2011. Dr. Benbow did not, however, provide explanation as to why appellant was disabled from his modified work as of January 20, 2011. The conditions which he continued to diagnose were the same conditions for which appellant sought medical treatment since 1994. Regarding the issue of disability, Dr. Benbow provided a conclusory opinion, but did not explain why appellant could not perform his modified work during the time period in question. The Board has found that medical reports containing no medical rationale are entitled to limited probative value and are generally insufficient to meet appellant's burden of proof.[10] Additionally, the diagnostic reports by Dr. Becker, Dr. Peake and Dr. Sory also contain no medical opinion as to whether appellant was disabled during the claimed period. As noted, it is appellant's burden to establish that he was disabled for work as a result of the accepted employment injury.[11] As the medical evidence failed to provide a rationalized medical opinion explaining why he was disabled due to his accepted back conditions, the Board finds that he failed to meet his burden of proof.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

LEGAL PRECEDENT -- ISSUE 2

Section 8103(a) of FECA provides for the furnishing of services, appliances and supplies prescribed or recommended by a qualified physician which OWCP, under authority delegated by the Secretary, considers likely to cure, give relief, reduce the degree or the period of disability or aid in lessening the amount of monthly compensation.[12] In interpreting the section 8103(a), the Board has recognized that OWCP has broad discretion in approving services provided under FECA to ensure that an employee recovers from his or her injury to the fullest extent possible in the shortest amount of time.[13] OWCP has administrative discretion in choosing the means to achieve this goal and the only limitation on the OWCP's authority is that of reasonableness.[14] Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable

[10] *Elizabeth H. Kramm,* 57 ECAB 117, 124 (2005); *Jimmie H. Duckett,* 52 ECAB 332, 336 (2001); *Ceferino L. Gonzales,* 32 ECAB 1591 (1981).

[11] *Sandra D. Pruitt, supra* note 6.

[12] 5 U.S.C. § 8103; *see Thomas W. Stevens,* 50 ECAB 288 (1999).

[13] *W.T.,* Docket No. 08-812 (issued April 3, 2009); *A.O.,* Docket No. 08-580 (issued January 28, 2009).

[14] *D.C.,* 58 ECAB 629 (2007); *Mira R. Adams,* 48 ECAB 504 (1997).

exercise of judgment or actions taken which are contrary to both logic and probable deductions from established facts. It is not enough to merely show that the evidence could be construed so as to produce a contrary factual conclusion.[15]

Section 8123(a) of FECA 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 who shall make an examination.[16]

ANALYSIS -- ISSUE 2

As noted above, OWCP accepted the conditions of lumbar sprain and degenerative disc disease. On November 16, 2010 Dr. Benbow requested authorization for lumbar spinal fusion surgery. OWCP denied authorization based on the opinion of Dr. Van Hal, a Board-certified orthopedic surgeon, who performed a second opinion examination. The Board finds that there is a conflict in medical opinion between appellant's physicians, Drs. Benbow and Rimlawi and OWCP's physician, Dr. Van Hal, as to whether the recommended back surgery is medically warranted.

Appellant provided various medical reports by Dr. Benbow, who diagnosed lumbosacral disc degeneration and sprain of lumbar region. In a September 16, 2010 report, Dr. Benbow recommended a spinal fusion surgery at the L5-S1 level based on the progression of appellant's pain and ongoing debilitating nature. He also pointed out that appellant had limited response to other conservative treatments for his back pain and referred him for a second opinion. In a November 4, 2010 report, Dr. Benbow stated that appellant needed surgery as quickly as possible and pointed out that he was an excellent candidate for this surgery due to his severe loss of disc height and degenerative disc at the L5-S1 level. In an October 21, 2010 report, Dr. Rimlawi agreed with Dr. Benbow's opinion and stated that "an L5-S1 fusion surgery [was] warranted by this patient."

Dr. Katz, an OWCP medical adviser, opined that the objective pathology including MRI scans and electrodiagnostic studies, did not clearly correlate with appellant's degree of subjective complaints, physical findings or the extent of the proposed surgery and referred him for a second-opinion examination. Dr. Van Hal, the second-opinion examiner, determined that the examination of appellant did not support the need for lumbar spinal fusion surgery. He explained that lumbar spinal fusion surgery for a patient who did not have spine instability or a fracture was not fully supported by the evidence. Thus, the medical evidence was in conflict as to whether the surgery was medically necessary.

OWCP forward Dr. Van Hal's report to the treating physician and noted: "If no response is received … by March 24, 2011 … your lack of response will constitute agreement with … Dr. Van Hal." Based simply on the lack of timely response from Dr. Benbow, Dr. Van Hal's medical evidence was determined to be uncontroverted. The Board finds the absence of a

[15] *L.W.*, 59 ECAB 471 (2008); *P.P.*, 58 ECAB 673 (2007); *Daniel J. Perea*, 42 ECAB 214 (1990).

[16] 5 U.S.C. § 8123(a); *Darlene R. Kennedy*, 57 ECAB 414 (2006); *Dale E. Jones*, 48 ECAB 648 (1997).

response from Dr. Benbow is insufficient to declare the absence of a conflict. It still existed at the date of the decision.

The case will be referred to an impartial medical specialist to resolve the conflict regarding the necessity of the requested surgery.[17] On remand, OWCP should refer appellant, together with the case file and the statement of accepted facts, to an appropriate specialist for an impartial medical evaluation. After such further development as it deems necessary, OWCP should issue an appropriate decision regarding appellant's request for surgery.

CONCLUSION

The Board finds that appellant failed to establish that he was disabled commencing January 20, 2011 as a result of his accepted lumbar conditions. The Board also finds that this case is not in posture for a decision regarding whether back surgery was warranted.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 28, 2011 is affirmed in part and set aside and remanded in part.

Issued: June 6, 2012
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

[17] *M.C.*, Docket No. 09-1974 (issued July 13, 2010); *see also Y.A.*, 59 ECAB 701 (2008); *Bryan O. Crane*, 56 ECAB 713 (2005).