United States Department of Labor
Employees' Compensation Appeals Board

A.D., Appellant	)	
and	)	**Docket No. 15-0730**
	)	**Issued: October 2, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Severna Park, MD, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On February 4, 2014 appellant, through counsel, filed a timely appeal from a November 7, 2014 merit decision of the Office of Workers' Compensation (OWCP) Programs. 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 the case.

ISSUES

The issues are: (1) whether OWCP met its burden of proof to justify termination of appellant's compensation benefits for his accepted injury effective December 12, 2013; and (2) whether appellant established continuing disability or residuals of his accepted conditions after December 12, 2013.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On August 27, 2012 appellant, then a 36-year-old letter carrier, injured his back while moving bags of mail. OWCP accepted his claim for lumbar sprain. Appellant stopped work on August 27, 2012 and did not return.

Appellant submitted an October 5, 2010 magnetic resonance imaging (MRI) scan of the lumbar spine which revealed grade 1 anterolisthesis with bilateral spondylolysis, severe biforaminal narrowing at L5-S1, degenerative changes, disc protrusions at L2 through L5, and facet arthropathy. A October 26, 2012 lumbar MRI scan showed stable grade 1 anterolisthesis of L5 due to bilateral spondylolysis, severe bilateral foraminal narrowing at L5, stable mild bilateral foraminal, moderate left lateral recess narrowing at L2-3, annular spondylotic disc bulge, and small focal left paracentral disc protrusion. Appellant was treated by Dr. John Barry, a Board-certified orthopedic surgeon, from October 8, 2012 to February 25, 2013, for low back pain. Dr. Barry reported 10 years of episodic lumbosacral back pain with no prior injury. He diagnosed lumbar disc degeneration, lumbosacral radiculopathy, and lumbosacral spondylosis. On February 25, 2013 Dr. Barry advised that conservative treatment failed and he recommended a laminectomy.

On March 8, 2013 OWCP referred appellant's case record to its medical adviser for an opinion of whether his condition should be expanded and whether the spinal fusion was needed due to the work injury. On March 24, 2013 the medical adviser noted that the October 5, 2010 MRI scan was about two years before the work injury and, at the time, appellant had both back pain as well as right leg radicular pain. An MRI scan was repeated two years later and there were no changes noted between the 2010 and the 2012 MRI scan studies. The medical adviser opined that based upon these facts, he did not find that surgery was indicated as a result of the August 27, 2012 injury. He opined that the lumbar sprain was resolved and the ongoing complaints were due to the preexisting history of significant back and leg pain.

Appellant came under the treatment of Dr. Timothy F. Witham, a Board-certified neurosurgeon, on April 24, 2013. He reported initially injuring his back at home in 2010. Appellant noted that on August 12, 2012, while lifting and moving mail bundles, he felt a sharp and acute back pain. Dr. Witham diagnosed spondylolisthesis with intractable and worsening back pain, radiculopathy, and instability. He recommended a L5-S1 decompression and discectomy. Dr. Witham noted that appellant continued with residuals of the work injury and he believed the proposed surgery was medically necessary due to instability and radiculopathy. An April 29, 2013 duty status report diagnosed lumbar spondylosis and noted that appellant was totally disabled. A May 6, 2013 lumbar MRI scan revealed bilateral spondylolysis with grade 1 anterior spondylolisthesis of the L5 vertebra, no significant canal narrowing at L5-S1, moderate-to-severe foraminal narrowing bilaterally, compression of the exiting L5 nerve roots, mild degenerative changes at L2-5, and a small left herniation at L2-3.

On June 10, 2013 OWCP referred appellant to Dr. Stuart J. Gordon, a Board-certified orthopedic surgeon, to determine if the accepted condition had resolved. In a July 1, 2013 report, Dr. Gordon indicated that he reviewed the records provided and examined appellant. He advised that appellant had an "extensive" lumbar history going back to a 2003 injury sustained when loading a truck and another event in 2010 when he was cutting his toenails. Dr. Gordon noted

findings on examination of full range of motion in the cervical and thoracic spine, pain in the lumbar spine, negative straight-leg raise test bilaterally, and intact motor and sensory reflexes. He diagnosed preexisting long history of back pain, low-grade spondylolisthesis, preexisting degenerative disease of the lumbar spine and spondylolisthesis unrelated to the work injury, increased back pain on August 27, 2012, aggravation of preexisting condition, pelvic obliquity with right leg shorter than left, and possible spondylitic stenosis at L2-3. Dr. Gordon opined that the proposed surgery was not related to the August 27, 2012 work injury, but rather it was related to long-standing, preexisting lumbar disease which was previously treated and documented by the October 5, 2010 MRI scan. He noted other contributing factors of nonindustrial preexisting limb-length discrepancy, multilevel degenerative disease, and preexisting spondylolisthesis. In a July 1, 2013 work capacity evaluation, Dr. Gordon noted that appellant could return to work with restrictions.

On July 18, 2013 OWCP requested Dr. Gordon clarify his opinion. In a supplemental report dated July 22, 2013, Dr. Gordon advised appellant's current complaints were the progression of preexisting underlying degenerative disease and spondylolisthesis of the lumbar spine. He noted that the postinjury MRI scan revealed no significant change in the anatomic alignment of the spine and there was no objective evidence of an aggravation beyond the subjective reporting. Dr. Gordon opined that the permanent restrictions were based on appellant's preexisting conditions and not the event of August 27, 2012.

Appellant submitted a July 30, 2013 report from Dr. Witham who noted his opinions were in conflict with Dr. Gordon. Dr. Witham opined that objective data showed that appellant's condition was exacerbated following his injury in August 2012. He further noted that imaging showed objective instability at the L5-S1 segment after the injury in 2012 that warranted approval of surgery.

OWCP found that a conflict of medical opinion existed between Dr. Witham, who found appellant had ongoing work-related residuals including the need for L5-S1 surgery, and Dr. Gordon, who opined that appellant's accepted condition had resolved and that appellant's residuals and the proposed surgery were related to preexisting disease.

To resolve the medical conflict, on September 12, 2013, OWCP referred appellant to Dr. Edward R. Cohen, a Board-certified orthopedic surgeon. In an October 3, 2013 report, Dr. Cohen noted reviewing the record, including the history of appellant's work injury, and examining him. He noted appellant's history was significant for an episode of low back pain while loading a truck at work in 2001 or 2002 and in 2010 when he bent over to clip his nails. Examination of the back revealed no visible or palpable muscle spasm, mild restriction in flexion, moderate restriction in extension, no point tenderness or dysmetria, negative straight leg raising test bilaterally, and no localized sensory loss or weakness. Dr. Cohen diagnosed resolved back sprain, preexisting multilevel degenerative disc disease, and unrelated symptomatic grade 1 spondylosis at L5-S1. He concluded that appellant reached maximum medical improvement as it related to the work injury. Dr. Cohen opined that appellant sustained a simple sprain which resolved and his ongoing back complaints were causally related to long-standing degenerative lumbar disc disease, arthritis, and grade 1 spondylolisthesis. He further opined that the ongoing disability was caused by the chronic degenerative disc disease and arthritis mentioned above. Dr. Cohen noted the surgery recommended was reasonable and necessary, but not causally

related to the work injury. Rather, he opined that the proposed surgery was due to the long-standing degenerative lumbar disc disease, arthritis, and spondylosis. Dr. Cohen noted that appellant did not require further evaluation, treatment, or restrictions as it related to the work injury. In an OWCP-5 form, he noted that appellant was unable to work due to degenerative and congenital spinal disease, but the restrictions were due to his nonwork-related condition. Dr. Cohen noted that appellant reached maximum improvement with regard to the August 27, 2012 work injury.

On November 1, 2013 OWCP proposed to terminate all benefits finding that Dr. Cohen's report established no continuing residuals of his work-related lumbar sprain.

On November 19, 2013 appellant, through counsel, disagreed with the proposed termination and asserted that his condition worsened as a direct result of the accident on August 27, 2012. He submitted reports from Dr. Witham dated July 25 and August 14, 2013 who noted that appellant had clear cut instability and spondylolisthesis that was symptomatic at the L5-S1 segment. Dr. Witham noted that, after the August 2012 injury, his diagnosed spondylosis and symptoms were more severe. He opined that appellant's preexisting condition was exacerbated by the August 12, 2012 injury and caused instability at the L5-S1 segment requiring surgical intervention. Appellant submitted a November 26, 2013 report from a physician assistant who diagnosed sciatica due to lumbar disc displacement, thoracic or lumbar radiculitis, chronic pain syndrome, spinal stenosis of the lumbar region, and acquired spondylolisthesis.

In a decision dated December 12, 2013, OWCP terminated appellant's medical and wage-loss compensation benefits effective the same day finding that the medical evidence established that he had no continuing residuals of his accepted conditions.

On December 23, 2013 counsel requested an oral hearing which was held on August 18, 2014. Appellant submitted physical therapy notes from March 5 to 19, 2013. Also submitted was a December 31, 2013 report from Dr. Robert Rankin, a Board-certified orthopedic surgeon, who treated appellant for back, leg, and muscle pain. Dr. Rankin diagnosed thoracic and lumbar radiculitis, sciatica due to displacement of lumbar disc, spinal stenosis of lumbar region, acquired spondylolisthesis, and chronic pain syndrome. A January 18, 2014 duty status report from Dr. Witham diagnosed exacerbation of spondylolisthesis and noted that appellant could not return to work. On April 17, 2014 Dr. Witham noted that due to appellant's intractable mechanical low back pain, new onset of radiculopathy, and new L5-S1 instability after his August 27, 2012 injury, he recommended L5-S1 decompression and fusion. He opined to a reasonable degree of medical certainty that the August 27, 2012 back injury appellant sustained at work was a substantial factor contributing to his spinal condition and required surgery. A May 13, 2014 MRI scan of the lumbar spine revealed bilateral spondylosis of L5, bilateral foraminal narrowing compounded by right foraminal disc protrusion resulting in flattening of the L5 nerve roots, subacute compression deformity of the endplate at L3, and moderate L2-3 paracentral disc protrusion.

In a decision dated November 7, 2014, the hearing representative affirmed the December 12, 2013 decision.

LEGAL PRECEDENT -- ISSUE 1

Once OWCP accepts a claim, it has the burden of justifying termination or modification of compensation benefits.[2] After it has determined that an employee has disability causally related to his or her federal employment, OWCP may not terminate compensation without establishing that the disability has ceased or that it is no longer related to the employment.[3] The right to medical benefits for an accepted condition is not limited to the period of entitlement for disability. To terminate authorization for medical treatment, OWCP must establish that a claimant no longer has residuals of an employment-related condition, which requires further medical treatment.[4]

Section 8123(a) 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.[5]

ANALYSIS -- ISSUE 1

OWCP accepted appellant's claim for lumbar sprain. It found that a conflict in medical opinion existed between Dr. Witham, appellant's physician who indicated that appellant had disabling residuals of her work injuries and required L5-S1 surgery causally related to the August 27, 2012 work injury, and Dr. Gordon, an OWCP referral physician who opined that appellant's accepted condition had resolved and that continuing residuals, disability, and the need for surgery were attributable only to his preexisting conditions. Consequently, OWCP referred appellant to Dr. Cohen to resolve the conflict.

The Board finds that the opinion of Dr. Cohen is sufficiently well rationalized and based upon a proper factual background such that it is entitled to special weight to establish that the disabling residuals of appellant's work-related conditions have ceased.[6]

In an October 3, 2013 report, Dr. Cohen reviewed appellant's history, noted findings and determined that appellant had no objective complaints or findings from the accepted conditions. He noted appellant's history was significant for an episode of low back pain while loading a truck at work in 2001 or 2002. Dr. Cohen noted an essentially normal examination with no point tenderness or dysmetria, negative straight leg raises bilaterally, and no localized sensory loss or weakness. He diagnosed a resolved back sprain, preexisting and unrelated multilevel degenerative changes, and grade 1 spondylosis at L5-S1. Dr. Cohen opined that appellant sustained a simple sprain which resolved and his ongoing back complaints were the result of

[2] *Gewin C. Hawkins*, 52 ECAB 242 (2001); *Alice J. Tysinger*, 51 ECAB 638 (2000).

[3] *Mary A. Lowe*, 52 ECAB 223 (2001).

[4] *Id.; Leonard M. Burger*, 51 ECAB 369 (2000).

[5] 5 U.S.C. § 8123(a). *See Guiseppe Aversa*, 55 ECAB 164 (2003).

[6] *Solomon Polen*, 51 ECAB 341 (2000). *See* 5 U.S.C. § 8123(a). Where there exists a conflict of medical opinion and the case is referred to an impartial specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, is entitled to special weight.

chronic long-standing degenerative lumbar disc disease, arthritis, and grade 1 spondylolisthesis. He noted appellant's ongoing disability was caused by the chronic degenerative disc disease and arthritis. Dr. Cohen opined that the recommended surgery was the result of long-standing degenerative lumbar disc disease, arthritis, and spondylosis and not causally related to the work injury. He indicated that appellant did not require further evaluation, treatment, or restrictions as it related to the above work injury. In an OWCP-5 form, Dr. Cohen opined that appellant was unable to work due to degenerative and congenital spinal disease and any restrictions were due to his nonwork-related condition.

The Board finds that Dr. Cohen had full knowledge of the relevant facts and evaluated the course of appellant's condition. Dr. Cohen is a specialist in the appropriate field. He did not indicate that there was a work-related reason for disability or treatment. Dr. Cohen's opinion, as set forth in his report of October 3, 2013, is found to be probative evidence and reliable. The Board finds that his opinion constitutes the weight of the medical evidence and is sufficient to justify OWCP's termination of wage-loss and medical benefits for the accepted conditions.

Subsequent to Dr. Cohen's report, appellant submitted reports from Dr. Witham dated July 25 to August 14, 2013 which noted that appellant had clear cut instability and spondylolisthesis that was symptomatic at the L5-S1 segment. Dr. Witham noted that appellant had spondylosis which was more severe following the August 2012 injury. He opined that the preexisting condition was exacerbated by the August 12, 2012 injury and caused instability at the L5-S1 segment requiring surgery. However, Dr. Witham did not specifically address how any continuing condition or medical restrictions were causally related to the accepted August 27, 2012 employment injury. The Board has found that vague and unrationalized medical opinions on causal relationship have little probative value.[7] It is noted that Dr. Witham had been on one side of the conflict resolved by Dr. Gordon and his reports are similar to his prior reports and are insufficient to overcome that of Dr. Cohen or to create a new medical conflict.[8]

On appeal, appellant, through counsel, argues that Dr. Cohen's report was vague, and insufficient to be the weight of the evidence in terminating appellant's benefits. He specifically asserted that Dr. Cohen's report did not adequately detail the physical findings and was based on an inaccurate factual history. Appellant asserted that he provided abundant medical evidence to show his residuals from the work injury and the necessary low back surgery. The Board finds that the October 3, 2013 report from Dr. Cohen provided adequate findings on examination. The report specifically noted that appellant's back revealed no visible or palpable muscle spasm, no point tenderness or dysmetria, negative straight leg raising and no localized sensory loss or weakness. Dr. Cohen found no clinical findings of residuals or disability causally related to the accepted back sprain. He explained that appellant's ongoing back complaints and disability were causally related to long-standing degenerative lumbar disc disease, arthritis and grade 1 spondylolisthesis. Dr. Cohen noted the recommended surgery was reasonable and necessary but

[7] *Jimmie H. Duckett*, 52 ECAB 332 (2001); *Franklin D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value).

[8] *See Michael Hughes*, 52 ECAB 387 (2001); *Howard Y. Miyashiro*, 43 ECAB 1101, 1115 (1992); *Dorothy Sidwell*, 41 ECAB 857 (1990). The Board notes that Dr. Cohen's reports do not contain new findings or rationale upon which a new conflict might be based.

not causally related to the work injury. He found that proposed surgery was necessary because of long-standing degenerative lumbar disc disease, arthritis, and spondylosis. The reports from Drs. Witham and Rankin, do not explain how any continuing disability was causally related to the accepted employment injury.

Appellant submitted a November 26, 2013 report from a physician assistant. However, the Board has held that treatment notes signed by a physician assistant are not considered probative medical evidence as these providers are not a physician under FECA.[9]

LEGAL PRECEDENT -- ISSUE 2

As OWCP met its burden of proof to terminate appellant's compensation benefits, the burden shifted to him to establish continuing disability causally related to his accepted employment injury.[10] To establish causal relationship between the claimed disability and the employment injury, appellant must submit rationalized medical opinion evidence based on a complete factual and medical background supporting such a causal relationship.[11]

ANALYSIS -- ISSUE 2

The Board finds that appellant has not established that he has any continuing residuals of his work-related lumbar subluxation, lumbosacral strain/sprain, and left sacroiliac sprain and expanded his claim to include left S1 sacroiliitis, on or after December 12, 2013.

After the termination of benefits on December 12, 2013, appellant submitted a January 18, 2014 duty status report from Dr. Witham who diagnosed exacerbation of spondylolisthesis and noted that appellant could not return to work. Similarly, in an April 17, 2014 report, Dr. Witham opined that to a reasonable degree of medical certainty the August 27, 2012 injury was a substantial factor in contributing to appellant's spinal condition. However, his opinion on causal relationship is similar to his previous opinions on this matter. Submitting a report from a physician who was on one side of a medical conflict that an impartial specialist resolved is, generally, insufficient to overcome the weight accorded to the report of the impartial medical examiner or to create a new conflict.[12]

Appellant submitted a December 31, 2013 report from Dr. Rankin who treated him for back, leg, and muscle pain. However, Dr. Rankin neither noted a history of injury or the employment factors believed to have caused or contributed to appellant's condition.[13]

[9] *See David P. Sawchuk*, 57 ECAB 316 (2006) (lay individuals such as physician assistants, nurses and physical therapists are not competent to render a medical opinion under FECA); 5 U.S.C. § 8101(2) (this subsection defines a "physician" as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law).

[10] *See Joseph A. Brown, Jr.*, 55 ECAB 542 (2004); *Manuel Gill*, 52 ECAB 282 (2001).

[11] *Daniel F. O'Donnell, Jr.*, 54 ECAB 456 (2003).

[12] *Jaja K. Asaramo*, 55 ECAB 200 (2004); *see also supra* note 8.

[13] *Frank Luis Rembisz*, 52 ECAB 147 (2000) (medical opinions based on an incomplete history or which are speculative or equivocal in character have little probative value).

Additionally, he failed to provide a specific or a rationalized opinion regarding the causal relationship between appellant's thoracic and lumbar radiculitis, sciatic, spinal stenosis, acquired spondylolisthesis, and chronic pain syndrome and the factors of employment believed to have caused or contributed to such condition.[14]

Appellant also submitted physical therapy notes. The Board has held that treatment notes signed by a physical therapist are not considered medical evidence as these providers are not considered a physician under FECA.[15] Additionally, appellant submitted a May 13, 2014 MRI scan of the lumbar spine. However, this evidence is of limited probative value as it was not accompanied by a physician's explanation regarding how any medical condition was due to his August 27, 2012 work injury.

Consequently, appellant did not establish that he has any employment-related condition or disability after December 12, 2013.

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.

CONCLUSION

The Board finds that OWCP has met its burden of proof to terminate benefits effective December 12, 2013.

[14] *See Jimmie H. Duckett*, *supra* note 7.

[15] *See David P. Sawchuk*, *supra* note 9.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 7, 2014 is affirmed.

Issued: October 2, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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