United States Department of Labor
Employees' Compensation Appeals Board

D.H., Appellant	)	
and	)	**Docket No. 17-0178**
	)	**Issued: May 10, 2017**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Philadelphia, PA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On November 3, 2016 appellant filed a timely appeal from a September 30, 2016 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.

ISSUE

The issue is whether appellant has met his burden of proof to establish an injury causally related to a May 23, 2016 employment incident.

FACTUAL HISTORY

On June 14, 2016 appellant, then a 50-year-old housekeeping aid, filed a traumatic injury claim (Form CA-1) alleging that while cleaning a room on May 23, 2016 he felt pain in the

[1] 5 U.S.C. § 8101 *et seq.*

lower right side of his back and sustained a lower back strain. He stopped work on May 23, 2016 and returned to work on May 27, 2016.

Appellant was treated by Dr. Christopher T. Plastaras, a Board-certified physiatrist, on June 14, 2016, who took appellant off work from June 14 to 27, 2016.[2] On June 14, 2016 he was also treated by Dr. Marzena M. Buzanowska, a Board-certified physiatrist, for low back pain. Dr. Buzanowska noted a magnetic resonance imaging (MRI) scan of the lumbar spine revealed left L5-S1 radiculopathy, large left L4-5 interior foraminal disc extrusion with left L4-5 and right L4-5 foraminal stenosis, and left L3-4 disc protrusion with left L3-4 foraminal stenosis. She noted that appellant's history was significant for transforaminal epidural steroid injections at L4-5 and L5-S1. Dr. Buzanowska diagnosed right-sided low back pain with sciatica, essential hypertension, depression, and degeneration of the lumbar or lumbosacral intervertebral disc. She recommended physical therapy, avoid prolonged sitting, use of lumbar support, and right S1 transforaminal epidural steroid injection.

On June 28, 2016 appellant was treated by Dr. Gerard T. Hart, a Board-certified physiatrist, for low back pain and sciatica. He noted that appellant received a steroid injection with some improvement, but still had significant pain and was unable to stand for any length of time or work. Dr. Hart noted active problems of left L5-S1 radiculopathy, left L3-4 and L4-5 disc extrusions, sciatica, and gout. He indicated that a lumbar MRI scan revealed a large inferior L4-5 disc extrusion. Appellant's past history included left anterior cruciate ligament (ACL) surgery in the 1990's and transforaminal epidural lumbar steroid injections on September 10, 2013 and June 23, 2016. Findings on physical examination revealed tenderness of the right sciatic notch, positive straight leg test on the right, mild decreased strength in the right hip flexors, and decreased distal reflexes bilaterally. Dr. Hart diagnosed left L5-S1 radiculopathy, large left L4-5 interior foraminal disc extrusion, left L4-5 and right L4-5 foraminal stenosis, left L3-4 disc protrusion, left L3-4 foraminal stenosis, essential hypertension, and left knee pain.

Appellant submitted a July 25, 2016 attending physician's report from Dr. Ibrahim A. Usman-Oyowe, a Board-certified physiatrist, who noted that on May 23, 2016 appellant bent down to clean and when he attempted to rise he felt back pain. Dr. Usman-Oyowe noted no concurrent or preexisting injury or disease. He diagnosed lumbar disc degeneration and noted by checking a box marked "yes" that this condition was caused by bending and twisting at work. Dr. Usman-Oyowe provided transforaminal injections and found that appellant was totally disabled from June 14 to July 14, 2016 and could return to light duty on August 7, 2016. On July 27, 2016 he noted treating appellant on June 14, 2016 for low back and right leg pain that started on May 23, 2016 when appellant bent down to clean a toilet at work. Examination revealed pain with flexion and bending, and also weakness of his right ankle. Diagnostic testing revealed an L4-5 diffuse posterior disc bulge with superimposed left paracentral disc extrusion which was causing mild central stenosis, bilateral lateral recess stenosis, bilateral ligamentum flavum, and facet joint hypertrophy impinging on the traversing left L5 nerve root. Dr. Usman-Oyowe diagnosed lumbar disc disease with disc extrusion at L4-5 and mild central canal stenosis. He recommended physical therapy, lumbar support, and avoiding prolonged sitting.

[2] The record also includes an incomplete copy of a June 2, 2016 medical report that diagnosed right-sided sciatica. It did not address the cause of the diagnosed condition and there is no indication that it was authored by a physician.

Dr. Usman-Oyowe noted that appellant had transforaminal epidural steroid injections on June 23 and July 25, 2016. He opined that "bending at the job could have worsened low back pain. Disc extrusion described below could have been as result of sharp turn or bending and lifting heavy objects." Dr. Usman-Oyowe recommended that appellant limit lifting objects heavier than 10 pounds and avoid bending and twisting.

In a report dated July 8, 2016, Dr. William Bonner, a Board-certified physiatrist, noted seeing appellant on June 14, 2016 for worsening back pain. He indicated that appellant had temporary relief with a transforaminal epidural lumbar steroid injection on June 23, 2016, but the pain returned with tingling in the right posterior calf. Dr. Bonner noted findings of antalgic gait and intact strength and reflexes in the bilateral lower extremities. He diagnosed right low back and L5 radicular pain, a large L4-5 inferior foraminal disc extrusion, left L4-5 and right L4-5 severe foraminal stenosis, left L3-4 disc protrusion, left L3-4 foraminal stenosis, depression, and essential hypertension. Dr. Bonner recommended physical therapy, a further epidural steroid injection, lumbar support, and avoiding prolonged sitting. On July 8, 2016 he noted diagnoses and referred appellant for physical therapy.

On August 11, 2016 appellant filed a claim for compensation (Form CA-7) for total disability for the period July 7 to August 11, 2016.

By letter dated August 19, 2016, OWCP advised appellant that his claim had originally been received as a simple, uncontroverted case which resulted in minimal or no time loss from work. It indicated that his claim was administratively handled to allow limited medical expenses, but the merits of the claim had not been formally adjudicated. OWCP advised that, because appellant filed a claim for wage loss his claim would be formally adjudicated. It requested that he submit additional information including a comprehensive medical report from his treating physician which included a reasoned explanation as to how the specific work factors or incidents identified by appellant had contributed to his claim.

In a narrative statement dated September 15, 2016, appellant indicated that on May 23, 2016 he was performing his housekeeping aid duties and was bending at the waist to clean under a toilet and, as he began to rise, he felt a sharp pain in his right lower back causing him to fall forward onto his left knee. He advised that when he was able to stand his low back pain worsened and he had difficulty moving his leg and had to drag it. Appellant reported an ACL tear in his left knee in 1990, which was surgically repaired and lumbar issues in 2013 or 2014. He submitted physical therapy reports from September 30, 2013 to August 10, 2016.

Dr. Buzanowska examined appellant on June 14, 2016 and diagnosed left L5-S1 radiculopathy, large left L4-5 interior foraminal disc extrusion with left L4-5 and right L4-5 foraminal stenosis, left L3-4 disc protrusion with left L3-4 foraminal stenosis, and degeneration of the lumbosacral intervertebral disc. She noted prior treatment and recommended physical therapy, avoiding prolonged sitting, and use of lumbar support when sitting.

On June 23, 2016 Dr. Plastaras administered a right S1 transforaminal epidural injection and noted appellant's diagnoses. A July 15, 2016 lumbar spine MRI scan revealed multilevel severe degenerative changes, central and foraminal stenosis, and impingement on left-sided L5 nerve root by extruded disc.

Appellant was seen by Dr. Usman-Oyowe on July 22 and August 5, 2016 for worsening right and left lateral thigh and leg pain. Diagnoses included lumbar degenerative disc disease, L5 radicular pain, a large L4-5 inferior foraminal disc extrusion with left L4-5 and right L4-5 severe foraminal stenosis, and left L3-4 disc protrusion with left L3-4 foraminal stenosis. Dr. Usman-Oyowe recommended physical therapy, a prednisone taper, and epidural steroids.

Appellant submitted a September 13, 2016 report from Dr. Michael D. Johnson, a Board-certified general surgeon, who treated him for low back pain. He reported while performing his housekeeping aide duties he bent down and reached under a toilet bowl and felt a sudden pain in his right lower back causing him to fall forward onto his left knee. When appellant was able to stand, his low back pain worsened and he had difficulty moving his right leg and had to drag it. He has not worked since the date of injury. Appellant reported lower back pain, right leg weakness, a sensation of tingling and numbness in his right leg and foot, and left hip pain. His prior history that was significant for a 1987 torn ACL of the left knee with surgical repair, an injury to his back in May 2014, and a May 2011 motor vehicle accident which resulted in an acute sprain and strain of the cervical and lumbar muscles as well as a left shoulder sprain and strain and traumatic myositis of the left upper trapezius. Dr. Johnson compared the July 15, 2016 MRI scan of the lumbar spine with the May 2011 MRI scan and advised that the degree of foraminal stenosis appeared to have increased, although he thought this may also be due to slight differences in technique. He indicated that a May 11, 2011 electromyogram (EMG) showed no evidence of lumbosacral radiculopathy, tarsal tunnel syndrome, sensory entrapment neuropathy, or peripheral neuropathy in the legs. Dr. Johnson noted findings of antalgic gait favoring the left leg, normal cervical and thoracic spine, and relative weakness of the right leg when compared to the left on flexion of the knee. Both patellar reflexes were diminished symmetrically, and the left knee was tender. Diagnoses included lumbar spinal disc herniation, lumbar spinal stenosis, lumbar spinal bilateral radiculopathy right greater than left, internal derangement left knee, internal derangement left hip, and gait disturbance. Dr. Johnson recommended chiropractic manipulation and trigger point injections for pain and spasm. He advised that appellant could not perform his work duties because it would exacerbate his symptoms. Dr. Johnson noted that appellant's prognosis was poor due to the long-standing nature of his other chronic conditions as well as what appeared to be an acute exacerbation of these conditions. He opined that with a reasonable degree of medical certainty the symptoms and findings were causally related to and an exacerbation of previous injuries, most significantly the radiculopathy symptoms which presented at the onset May 23, 2016.

By decision dated September 30, 2016, OWCP denied appellant's claim finding that the medical evidence of record was insufficient to establish the medical condition was causally related to the accepted work incident.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim including the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was filed within the applicable time limitation of FECA, that an injury was sustained in the performance of duty as alleged, and that any disability and/or specific condition for which compensation is claimed are causally related to

the employment injury. These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[3]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether fact of injury has been established. There are two components involved in establishing fact of injury. First, the employee must submit sufficient evidence to establish that he actually experienced the employment incident at the time, place, and in the manner alleged. Second, the employee must submit medical evidence to establish that the employment incident caused a personal injury.[4]

Rationalized medical opinion evidence is generally required to establish causal relationship. The opinion of the physician must be based on a complete factual and medical background, 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.[5]

ANALYSIS

Appellant reported having low back pain while performing his work duties on May 23, 2016. The evidence establishes that the injury occurred as alleged on May 23, 2016 as he was bending at the waist to clean under a toilet. However, the Board finds that appellant has not submitted sufficient medical evidence to establish that this work incident caused or aggravated his diagnosed lumbar conditions.

Appellant submitted a September 13, 2016 report from Dr. Johnson who diagnosed lumbar spinal disc herniation, lumbar spinal stenosis, lumbar spinal bilateral radiculopathy right greater than left, internal derangement left knee, internal derangement left hip, and gait disturbance. He reported while performing his housekeeping aide duties he bent down and reached under a toilet bowl and felt a sudden pain in his right lower back causing him to fall forward onto his left knee. Dr. Johnson noted appellant's medical history was significant for an injury to his back in May 2014 and a May 2011 motor vehicle accident which resulted in an acute sprain and strain of the cervical and lumbar muscles. He opined that given a reasonable degree of medical certainty that appellant's symptoms and physical findings were causally related to and an exacerbation of previous injuries, most significantly, the radiculopathy symptoms which presented on May 23, 2016. The Board finds that, although Dr. Johnson supported causal relationship, he did not provide medical rationale explaining the basis of his opinion regarding the causal relationship between appellant's lumbar condition and the May 23, 2016 employment incident.[6] For example, Dr. Johnson did not explain the process by which

[3] *Gary J. Watling*, 52 ECAB 357 (2001).

[4] *T.H.*, 59 ECAB 388 (2008).

[5] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[6] *See T.M.*, Docket No. 08-975 (issued February 6, 2009) (a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale).

bending down and reaching under a toilet bowl and then standing erect would cause or aggravate the diagnosed condition and why such condition would not be due to any nonwork factors such as the May 2014 back injury, the motor vehicle accident in May 2011, or his diagnosed age-related degenerative changes.[7] Therefore, this report is insufficient to meet appellant's burden of proof.

In a July 27, 2016 report, Dr. Usman-Oyowe treated appellant on June 14, 2016 for low back and right leg pain that started after he bent down to clean toilet at work on May 23, 2016. He diagnosed lumbar disc disease with disc extrusion at L4-5 and mild central canal stenosis. Dr. Usman-Oyowe opined that bending at the job "could have" worsened appellant's low back pain and the disc extrusion described "could have" been as result of sharp turn or bending and lifting heavy objects. While he provides some support for causal relationship his opinion is insufficient to establish that the claimed lumbar condition was causally related to appellant's employment duties. However, this opinion is of limited probative value as it provides only speculative support for causal relationship.[8] In a July 25, 2016 attending physician's report, Dr. Usman-Oyowe diagnosed lumbar disc degeneration and noted by checking a box marked "yes" that the lumbar disc herniation was caused by bending and twisting at work. The Board has held that when a physician's opinion on causal relationship consists only of checking "yes" to a form question, without explanation or rationale, that opinion is of diminished probative value and is insufficient to establish a claim.[9] Dr. Usman-Oyowe has provided no medical rationale explaining the reasons for his opinion on causal relationship. Other reports he had authored are of limited probative value as they do not specifically address whether appellant's employment activities had caused or aggravated a diagnosed medical condition.[10] Therefore, Dr. Usman-Oyowe's opinion is insufficient to meet appellant's burden of proof.

Appellant was treated by Dr. Hart on June 28, 2016, for low back pain and sciatica. Dr. Hart noted that appellant received a steroid injection with some improvement, but still had significant pain and was unable to stand for any length of time or return to work. Similarly, in a report dated July 8, 2016, Dr. Bonner noted diagnoses and indicated that appellant gained only temporary relief from steroid injections. However, these reports are insufficient to establish the claim as neither physician provided a history of injury[11] or specifically addressed whether appellant's employment activities had caused or aggravated a diagnosed medical condition.[12]

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

[8] Medical opinions that are speculative or equivocal in character are of diminished probative value. *D.D.*, 57 ECAB 734 (2006).

[9] *D.D.*, *id*; *Sedi L. Graham*, 57 ECAB 494 (2006).

[10] *A.D.*, 58 ECAB 149 (2006) (medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

[11] *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).

[12] *A.D.*, *supra* note 10.

A June 14, 2016 note from Dr. Plastaras indicated that appellant was off work from June 14 to 27, 2016. On June 23, 2016 he performed a right S1 transforaminal epidural injection and noted diagnoses. Similarly, on June 14, 2016 Dr. Buzanowska diagnosed right-sided low back pain with sciatica, essential hypertension, depression, and degeneration of the lumbar or lumbosacral intervertebral disc. She recommended physical therapy and transforaminal epidural steroid injections. However, these reports are insufficient to meet appellant's burden of proof as they did not address the cause of his claimed lumbar condition.[13]

Likewise, the other medical evidence of record, such as diagnostic test reports, is of limited probative value as it fails to provide an opinion on the causal relationship between appellant's job and his diagnosed lumbar condition.[14] For this reason, this evidence is insufficient to meet his burden of proof.

Appellant also submitted physical therapy reports. However, the Board has held that physical therapists are not considered physicians under FECA and their reports are of no probative value.[15] Thus, this evidence is insufficient to establish the claim.

An award of compensation may not be based on surmise, conjecture, or speculation. Neither the fact that appellant's condition became apparent during a period of employment nor the belief that his condition was caused, precipitated, or aggravated by his employment is sufficient to establish causal relationship. Causal relationship must be established by rationalized medical opinion evidence.[16] Appellant failed to submit such evidence and therefore 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.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish an injury causally related to a May 23, 2016 employment incident.

[13] *Id*.

[14] *See id.*

[15] *See David P. Sawchuk*, 57 ECAB 316, 320 n. 11 (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).

[16] *See Dennis M. Mascarenas*, 49 ECAB 215 (1997).

ORDER

IT IS HEREBY ORDERED THAT the September 30, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 10, 2017
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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