



## **FACTUAL HISTORY**

On February 19, 2013 appellant, then a 53-year-old city carrier, injured his back when stepping out of his mail truck. OWCP accepted his claim for lumbar strain and left sacroiliac strain. Appellant stopped work on February 19, 2013 and received wage-loss compensation benefits for intermittent periods of disability.

Appellant submitted a July 30, 2008 magnetic resonance imaging (MRI) scan which revealed a right paracentral disc protrusion at L4-5 with deviation of the right L4 nerve root, mild left-sided L4-5 facet arthropathy, and no evidence of spondylosis. A June 26, 2013 MRI scan indicated mild multilevel degenerative disc disease, facet joint osteoarthritis most pronounced at L4-5, and mild bilateral neural foraminal stenosis.

Appellant was treated by Dr. Jennifer L. Kurz, a Board-certified physiatrist. On June 25, 2014 Dr. Kurz diagnosed low back and leg pain. She administered a left L5-S1 interlaminar epidural steroid injection and sacroiliac joint injection with fluoroscopic needle guidance. In December 11, 2014 reports, Dr. Kurz noted that on February 19, 2013 appellant was stepping off his vehicle and sustained a back injury. She diagnosed lumbar spondylosis and sciatica and indicated that his condition was caused or aggravated by his employment. Dr. Kurz indicated that appellant could return to work with restrictions.

On February 5, 2015 Dr. Kurz noted appellant's complaints of severe chronic axial lower back pain with new radicular left leg pain. She indicated that he had known chronic lumbar spondylosis and lumbar facet pain which was responsive short term to facet injections. Appellant reported an increase in radicular neuropathic pain in the left L4-5 dermatomal distribution and pins and needles in his right foot. Dr. Kurz noted findings of limited lumbar extension, increasing axial facet pain, tenderness overlying the lumbar facet regions, pain along the left L4-5 dermatomes, decreased left hip flexor strength and left knee flexion strength, and reduced sensation along the right L5-S1. She diagnosed chronic axial lower lumbar spine pain from facet pain syndrome and spondylosis. Dr. Kurz recommended physical therapy and lumbar radiofrequency lesioning for the lower lumbar facets. In a March 2, 2015 duty status report (Form CA-17), she returned appellant to work with restrictions.

On March 2, 2015 OWCP authorized the sacroiliac joint injections performed on June 25, 2014.

Dr. Kurz subsequently requested authorization for a lumbar spine procedure designated as a destruction of lumbar sacroiliac facet joint (also referred to as lumbar facet radiofrequency intervention) on March 4, 2015.

By letter dated March 6, 2015, OWCP notified Dr. Kurz that her request for authorization of the lumbar procedure could not be approved at that time. It indicated that further medical development was required before the request could be approved or denied.<sup>3</sup>

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<sup>3</sup> OWCP continued to authorize Dr. Kurz' requests for foraminal epidural injections.

On April 20, 2015 OWCP requested that a district medical adviser (DMA) address whether the requested lumbar procedure was warranted and necessitated by the accepted lumbar strain and left sacroiliac strain of February 19, 2013. In a June 14, 2015 report, the DMA noted reviewing the medical record and a statement of accepted facts. He indicated that the proposed lumbar procedure, destruction of lumbosacral facet joint, should not be approved as warranted and necessitated by the work injury of February 19, 2013. The DMA noted that any invasive procedure would never be indicated for a diagnosed strain, which was a temporary, self-limiting soft tissue injury which would resolve expeditiously and uneventfully. He further indicated that records dating back to 2008 indicate a long-standing history of low back pain. The medical adviser referenced the July 30, 2008 lumbar MRI scan which revealed right paracentral disc protrusion at L4-5 with deviation of the right L4 nerve root, and mild left-sided L4-5 facet arthropathy. He opined that appellant underwent multiple facet joint and epidural injections without long-term efficacy. The DMA also indicated that the medical literature lacked long-term, controlled, double-blind studies validating a cure, or substantial benefit from destruction of lumbosacral facet joints. He opined that, based on the totality of the available medical documentation, the requested lumbar procedure was not medically necessitated, and certainly not causally related to the February 19, 2013 work injury.

By decision dated June 16, 2015, OWCP denied authorization for the requested lumbar procedure the evidence of record did not support that this procedure was medically necessary to address the effects of the accepted work-related conditions.

On June 22, 2015 appellant requested a telephone hearing before an OWCP hearing representative. On July 17, 2015 he withdrew his request for an oral hearing and requested reconsideration.

Evidence submitted in support of his request for reconsideration included additional reports from Dr. Kurz. In a December 11, 2014 report, Dr. Kurz noted that appellant presented with left axial lumbar facet pain from a work injury. She indicated that he responded well to lumbar facet injections and would be a candidate for lumbar facet radiofrequency lesioning. Dr. Kurz advised that this procedure would help target appellant's region of residual lumbar axial facet pain long-term. She noted examination findings of tenderness along the left L3-4 and L4-5 facet line and intact leg strength with the exception of left hip flexion weakness. Dr. Kurz diagnosed chronic axial spine pain. In a July 9, 2015 treatment note, she noted appellant's chronic axial low back pain from a work injury. Dr. Kurz noted his ongoing progressive chronic left-sided axial low back pain in the L4 and L5 lumbar facet regions was refractory to conservative therapies, including medications, physical therapy, and trigger point injections. Lidocaine and Marcaine injections provided temporary relief in symptoms. Dr. Kurz indicated that appellant was interested in pursuing lumbar radiofrequency denervation to help more permanently modify his severe, chronic, left lumbar facet pain. An accompanying July 9, 2015 letter requested approval for left L3-5 lumbar facet radiofrequency lesioning therapy. Dr. Kurz indicated that appellant underwent lumbar facet blocks with short-term relief and she opined that radiofrequency lesioning therapy would provide prolonged relief.

On September 17, 2015 Dr. Kurz noted treating appellant for progressive low back pain and leg weakness. Appellant underwent two sets of comparative dual diagnostic lumbar blocks with positive short-term pain relief. Dr. Kurz noted findings and diagnosed chronic low back

pain, deconditioning, and increased radicular pain sensation possibly from muscle tightness or myalgia rather than radiculopathy. She recommended aggressive reconditioning physical therapy and an electromyogram (EMG). On September 18, 2015 Dr. Kurz requested medical authorization for destruction of the lumbar sacral facet joint procedure.

By decision dated October 14, 2015, OWCP denied modification of its prior decision.

On December 16, 2015 appellant again requested reconsideration.

In support of his request, appellant submitted reports from Dr. Kurz dated April 16 and November 30, 2015 noting his treatment for chronic axial low back pain with increased radicular left leg pain. Dr. Kurz noted that he developed a right foot neuroma and underwent surgery.<sup>4</sup> She opined that appellant's back pain was likely at medical maximum improvement. Dr. Kurz noted his treatment and advised that lumbar epidural steroid injections and lumbar diagnostic facet blocks provided only temporary relief. She noted findings on physical examination and diagnosed ongoing radicular left L5 leg pain, chronic axial back pain, lumbar spondylosis and lumbar facet degenerative changes in the setting of work-related injury. Dr. Kurz recommended lumbar facet radiofrequency intervention to target appellant's facet pain permanently. She opined that his low back pain was all related to his work injury. A November 12, 2015 EMG of the lower extremities revealed no abnormalities.

In a medical necessity note dated November 30, 2015, Dr. Kurz diagnosed severe, chronic, progressive lumbar facet arthropathy attributable to a work injury sustained on June 19, 2013.<sup>5</sup> She indicated that, before the work injury, appellant did not suffer from terrible low back pain. Dr. Kurz opined that surgery would not help his pain, previous lumbar facet blocks were diagnostic/therapeutic for transient relief, and he was not a candidate for long-term opioid therapy. She advised that lumbar facet radiofrequency lesion intervention would give appellant more sustained relief and a better quality of life. Dr. Kurz also submitted form reports noting his status and his work restrictions. A lumbar spine x-ray dated November 30, 2015 revealed spondylolysis without spondylolisthesis at L5, mild rotatory scoliosis, and multilevel degenerative changes at L5-S1.

By decision dated January 29, 2016, OWCP denied modification of its October 14, 2015 decision.

On April 25, 2016 appellant again requested reconsideration. He submitted an April 14, 2016 report from Dr. Kurz who continued to treat him for chronic axial work-related low back pain. Dr. Kurz diagnosed chronic lumbar discogenic pain and recommended daily core conditioning and continued work modifications. In another April 14, 2016 report, she opined that appellant suffered from intractable lumbar discogenic pain radiating into the left hip and thigh in the L4-5 nerve root distribution. Dr. Kurz noted that MRI scan imaging revealed L4-5,

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<sup>4</sup> The record contains a June 23, 2015 report from Dr. Michael O'Gorman, a Board-certified general surgeon, who treated appellant for wound dehiscence status postsurgical repair of right foot Morton's neuroma. He diagnosed chronic ulcer of right foot.

<sup>5</sup> This appears to be a typographical error and should be February 19, 2013.

L5-S1 disc bulges and facet arthritis which can contribute to foraminal narrowing and compression of L4 and L5 nerve roots.

In an attending physician's report (Form CA-20) dated April 14, 2016, Dr. Kurz diagnosed lumbar facet arthropathy causing severe chronic low back pain. She noted by checking a box marked "yes" that appellant's condition was caused or aggravated by an employment activity. In a return to work slip dated April 14, 2016, Dr. Kurz continued appellant's work restrictions. On May 4, 2016 she performed a L4-5 interlaminar epidural steroid injection and diagnosed low back pain and leg pain.

In reports dated June 9 and 30, and August 22, 2016, Dr. Kurz noted appellant's treatment and diagnosed chronic, axial low back pain related to degenerative disc bulging, lumbar facet arthritis, and active trigger points in the lumbar paraspinals. She performed a trigger point injection at bilateral lumbar paraspinals. In a June 30, 2016 duty status report, Dr. Kurz continued appellant's work restrictions and on August 29, 2016, she diagnosed lumbar radiculopathy and advised that he was totally disabled. In a June 30, 2016 attending physician's report, she diagnosed lumbar facet arthropathy and lumbar degenerative disc disease causing severe low back pain. Dr. Kurz checked a box marked "yes" that appellant's condition was caused or aggravated by an employment activity. She continued his work restrictions. A June 30, 2016 return to work slip advised that appellant could return to work light duty with restrictions on lifting over 40 pounds. On August 29, 2016 Dr. Kurz indicated that he could return to work two days following an injection for pain management with additional restrictions.

By decision dated September 14, 2016, OWCP denied modification of its January 29, 2016 decision.

### **LEGAL PRECEDENT**

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.<sup>6</sup> In interpreting 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.<sup>7</sup> OWCP has administrative discretion in choosing the means to achieve this goal and the only limitation on OWCP's authority is that of reasonableness.<sup>8</sup>

Abuse of discretion is generally shown through proof of manifest error, clearly unreasonable exercise of judgment or actions taken which are contrary to both logic and probable

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<sup>6</sup> 5 U.S.C. § 8103(a).

<sup>7</sup> *Dale E. Jones*, 48 ECAB 648-49 (1997).

<sup>8</sup> *Daniel J. Perea*, 42 ECAB 214, 221 (1990) (holding that abuse of discretion by OWCP is generally shown through proof of manifest error, clearly unreasonable exercise of judgment, or administrative actions which are contrary to both logic, and probable deductions from established facts).

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.<sup>9</sup>

While OWCP is obligated to pay for treatment of employment-related conditions, appellant has the burden of proof to establish that the expenditure is incurred for treatment of the effects of an employment-related injury or condition.<sup>10</sup> Proof of causal relationship in a case such as this must include supporting rationalized medical evidence.<sup>11</sup> Therefore, in order to prove that the procedure is warranted, appellant must establish that the procedure was for a condition causally related to the employment injury and that the procedure was medically warranted. Both of these criteria must be met in order for OWCP to authorize payment.<sup>12</sup>

### ANALYSIS

In the present case, OWCP accepted that appellant sustained a lumbar strain and left sacroiliac strain on February 19, 2013. Appellant seeks authorization for a proposed destruction of the lumbosacral facet joint procedure. The Board finds that the medical evidence of record is insufficient to establish that the proposed procedure is causally related to the February 19, 2013 employment injury.

Appellant provided multiple reports from Dr. Kurz requesting approval for left L3-5 lumbar facet radiofrequency lesioning therapy. On December 11, 2014 and February 5, 2015 Dr. Kurz initially recommended lumbar radiofrequency lesioning for the lower lumbar facets. On July 9, 2015 she noted that facet blocks which only provided short-term relief from pain. Dr. Kurz advised that, because of the short-term nature of lumbar injections, appellant wanted to pursue radiofrequency lesioning therapy for prolonged relief. On November 30, 2015 she recommended lumbar radiofrequency lesioning and diagnosed severe, chronic, progressive lumbar facet arthropathy attributable to the work injury. Dr. Kurz also referenced appellant's preexisting lumbar condition and that, prior to the work event, he did not suffer from terrible low back pain. These reports are of diminished probative value. The Board initially notes that OWCP has only accepted a lumbar strain and left sacroiliac strain as a result of appellant's February 19, 2013 work injury, and there is no medical rationalized evidence to establish that other diagnosed conditions such as lumbar facet arthropathy, are causally related to the accepted injury.<sup>13</sup> Furthermore, an opinion that a condition is causally related to an employment injury because the employee was asymptomatic before the injury is insufficient, without supporting rationale, to support causal relationship.<sup>14</sup> The Board notes that these reports failed to provide a

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<sup>9</sup> *W.M.*, Docket No. 17-0337 (issued August 8, 2017).

<sup>10</sup> See *Debra S. King*, 44 ECAB 203, 209 (1992).

<sup>11</sup> *Id.*; see also *Bertha L. Arnold*, 38 ECAB 282 (1986).

<sup>12</sup> See *Cathy B. Millin*, 51 ECAB 331, 333 (2000).

<sup>13</sup> For conditions not accepted by OWCP as being employment related, it is the employee's burden of proof to provide rationalized medical evidence sufficient to establish causal relation, not OWCP's burden to disprove such relationship. *Alice J. Tysinger*, 51 ECAB 638 (2000).

<sup>14</sup> *Kimper Lee*, 45 ECAB 565 (1994).

rationalized opinion explaining how the proposed procedure was causally related to the accepted work injuries and why it was medically warranted. The need for rationale is particularly important where the record contains a July 30, 2008 MRI scan documenting preexisting low back condition, specifically a disc protrusion at L4-5 with deviation of the right L4 nerve root and left-sided L4-5 facet arthropathy.<sup>15</sup>

Similarly, reports from Dr. Kurz dated April 16, July 9, September 17 and November 30, 2015, and April 14, 2016 noted appellant's continued treatment for chronic axial low back pain from a work injury. She advised his condition was refractory to conservative therapies and indicated that he was interested in pursuing lumbar radiofrequency. Dr. Kurz diagnosed facet arthritis, degenerative disc disease, ongoing radicular left L5 leg pain, chronic axial back pain, and chronic lumbar discogenic pain due to the work injury. However, her reports failed to provide a rationalized opinion regarding causal relationship between the proposed lumbar procedure and the employment injury, and also addressing why the requested procedure was medically warranted.<sup>16</sup> Also, OWCP has not accepted that appellant sustained facet arthritis, degenerative disc disease or chronic lumbar discogenic pain as a result of his February 19, 2013 work injury, and there is no medical rationalized evidence to support such a conclusion.<sup>17</sup>

Other reports provided by Dr. Kurz are of limited probative value as they do not specifically address whether the requested procedure is causally related to the accepted lumbar strain and left sacroiliac strain and whether the procedure is medically warranted.<sup>18</sup>

Additionally, the Board notes that OWCP sought the advice of its medical adviser in this matter. In a June 14, 2015 report, OWCP's medical adviser has opined that the proposed lumbar facet radiofrequency lesioning procedure was not indicated in the treatment of appellant's employment-related injury of February 19, 2013. He noted that OWCP had only accepted strains and that an invasive procedure was not indicated for such conditions. The medical adviser also noted that the record indicated that appellant had a prior history of a low back condition and that medical literature did not support that the proposed procedure would offer substantial benefits.

The only limitation on OWCP's authority is approving or disapproving service under FECA is one of reasonableness.<sup>19</sup> Because appellant did not submit a reasoned medical opinion explaining how the February 19, 2013 work injury caused or contributed to his need for the requested procedure, OWCP properly acted within its discretionary authority to deny

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<sup>15</sup> See *S.C.*, Docket No. 17-0490 (issued June 27, 2017); *R.R.*, Docket No. 16-1118 (issued November 7, 2016) (the need for rationale is particularly important where the evidence indicated that appellant had a preexisting condition).

<sup>16</sup> *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).

<sup>17</sup> See *Alice J. Tysinger*, *supra* note 13.

<sup>18</sup> See *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).

<sup>19</sup> *Supra* note 8.

authorization for the requested procedure. Therefore, the Board finds that OWCP did not abuse its discretion under section 8103 in denying approval of lumbar procedure.

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 did not abuse its discretion by denying authorization for a lumbar procedure.

**ORDER**

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated September 14, 2016 is affirmed.

Issued: November 6, 2017  
Washington, DC

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

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

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