

FACTUAL HISTORY

On November 5, 2015 appellant then a 55-year-old air conditioning equipment mechanic, filed a traumatic injury claim (Form CA-1) alleging that, while moving a blood refrigerator out of an operating room closet from a stationary platform to a movable cart for transport on October 30, 2015, he sustained a lower left side muscle strain in his back. OWCP accepted appellant's claim for lumbar strain. Appellant did not stop work.

Appellant was treated by Dr. Ruth Kleinman, a Board-certified internist, on November 3, 2015 for a back strain. He reported that he felt lower left back pain on October 30, 2015 when he and a coworker maneuvered a blood refrigerator out of the closet onto a rolling cart and. Appellant noted continuing to work and notified his supervisor. Dr. Kleinman indicated that appellant presented with muscle tightness in the left lower to mid back without radiation. She noted findings on examination of no pain with palpation of the lower to mid back, intact bilateral upper and lower extremity motor strength, intact reflexes, and decreased range of motion of the back. Dr. Kleinman diagnosed back strain and prescribed medication. She returned appellant to work with restrictions.

Appellant came under the treatment of Dr. Svetlana Ilizarov, Board-certified in physical medicine and rehabilitation and sports medicine, on November 10, 2015 for low back pain beginning October 30, 2015. He related that he was maneuvering a refrigerator out of a closet and onto a rolling cart at work, which caused lower left back pain. Appellant noted having no history of low back pain prior to this incident. He reported muscle tightness, no radiation to the legs, tightness in the left gluteal area, and no bladder or bowel dysfunction. Appellant had pain with forward flexion and left lateral bending as well as motor strength weakness in the extensor hallucis longus (EHL) and left hip flexors. Dr. Ilizarov diagnosed left-sided low back pain with some EHL weakness and possible herniated pulposus. On December 14, 2015 she treated appellant for left sciatica. Appellant reported that his low back pain resolved completely, but he had ongoing left leg pain. Dr. Ilizarov noted findings of pain with forward flexion and left lateral bending, intact motor strength in the bilateral lower extremities, intact sensation and reflexes, and left calf pain with straight leg raises. She noted a November 30, 2015 magnetic resonance imaging (MRI) scan of the lumbar spine revealed L4-5 minimal-to-mild degeneration, moderate left paracentral caudal disc herniation producing moderate indentation on the left ventral thecal sac, and minimal/mild left greater than right neural foraminal impingement. Dr. Ilizarov diagnosed left-sided low back pain since October 30, 2015 when he maneuvered a refrigerator out of a closet at work, resolved, and two weeks later when his low back pain improved he developed radiating pain to the left lateral calf.

On January 11, 2016 she noted that appellant reported less leg pain at night and that the low back pain had resolved. Dr. Ilizarov noted pain with forward flexion and left lateral bending to the distal leg, motor strength weakness at left EHL, and left hamstring pain with straight leg raises. She diagnosed left-sided low back pain since the October 30, 2015 work incident, resolved, radiation of pain to the left lateral calf, left L5 radiculopathy, and L4-5 left paracentral caudal herniated nucleus pulposus confirmed by MRI scan.

By letter dated March 31, 2016, OWCP advised appellant that his claim originally appeared to be a minor injury which resulted in minimal or no time loss from work. It indicated

that the claim was administratively handled to allow limited medical payments, but the merits of the claim had not been formally adjudicated. OWCP advised that, because the medical benefits exceeded \$1,500.00, the claim would be formally adjudicated. It requested that appellant submit additional information including a comprehensive medical report from his treating physician, including a reasoned explanation as to how the specific work factors or incidents identified by appellant had contributed to his claimed injury.

On April 8, 2016 Dr. Ilizarov again treated appellant for worsening low back pain. She noted appellant was unable to sit due to pain. Motor examination revealed weakness on the left at EHL, and reflexes were absent at bilateral knees. Dr. Ilizarov noted a history of injury and indicated that appellant had initially been treated for left-sided low back pain and weakness in the EHL. Appellant developed radiation of pain to the left lateral calf two weeks later and left L5 radiculopathy due to disc herniation confirmed by MRI scan. Dr. Ilizarov noted that appellant currently had severe left-sided low back pain radiating to the left calf. She recommended an epidural injection and advised that appellant was off duty until April 15, 2016. On April 15, 2016 Dr. Ilizarov noted that appellant presented with significant symptom improvement within three days of taking Etodolac. She recommended an epidural injection and returned appellant to work with restrictions.

In a decision dated May 10, 2016, OWCP accepted appellant's claim for lumbar strain. It indicated that it continued to develop the additional diagnosed conditions which would be addressed in a different decision.

In a decision dated May 17, 2016, reissued on May 18, 2016, OWCP denied appellant's request to expand his claim to include minimal-to-mild degeneration and moderate left disc herniation, L4-5 minimal/mild left greater than right neural foraminal impingement, L5 radiculopathy, left side sciatica, mild-to-moderate desiccation of disc with mild diffuse bulging of annulus at L2-3, annular tear and mild central spinal stenosis at the L2-3 level. It found that the medical evidence of record was insufficient to establish that these diagnosed medical conditions were causally related to accepted work events.

On June 8, 2016 appellant requested an oral hearing which was held on August 23, 2016. He submitted additional evidence. In a June 3, 2016 report, Dr. Ilizarov treated appellant in follow up for low back pain and sciatica. Appellant reported feeling better, but experienced pain localized to the left buttock and posterior thigh area. Dr. Ilizarov noted findings of intact motor strength except for left EHL weakness and reflexes were absent at the bilateral knees. She noted a history of injury and appellant's subsequent treatment for left sided low back pain and weakness in the EHL. Appellant developed radiating of pain to the left lateral calf and L5 radiculopathy due to disc herniation confirmed by MRI scan. On April 8, 2016 he presented with exacerbation of left lumbar radiculopathy due to disc herniation which had improved with Etodolac and he returned to work with restrictions. Dr. Ilizarov diagnosed lumbar back pain, lumbar disc herniation, and left lumbar radiculopathy which was causally related to the October 30, 2015 injury at work. She recommended light-duty work with restrictions.

By decision dated October 31, 2016, an OWCP hearing representative affirmed the May 18, 2016 decision.

LEGAL PRECEDENT

Where an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.²

Causal relationship is a medical issue that must be established by rationalized medical opinion evidence.³ Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is causal relationship between the claimant's diagnosed condition and the implicated employment incident. The opinion of the physician must be based on a complete factual and medical background of the claimant, 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 incident identified by the claimant.⁴ The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.⁵

ANALYSIS

Appellant alleges that he developed a lumbar strain, minimal-to-mild degeneration and moderate left disc herniation, L4-5 minimal/mild left greater than right neural foraminal impingement, L5 radiculopathy, left side sciatica, mild-to-moderate desiccation of disc with mild diffuse bulging of annulus at L2-3, annular tear, and mild central spinal stenosis at the L2-3 level as a result of moving a refrigerator from a stationary platform to a movable cart for transport while at work on October 30, 2015. OWCP accepted the claim, as noted, for lumbar strain, but did not accept appellant's claim for the additional conditions. The Board finds that the medical evidence is insufficient to establish that the above-noted conditions were causally related to the October 30, 2015 work injury.

The medical records submitted most contemporaneously with the date of injury, note treatment for lower left back pain after appellant and a coworker maneuvered a blood refrigerator out of a closet onto a rolling cart. Specifically, notes from Dr. Kleinman, dated November 3, 2015, report treatment for low back pain. Dr. Kleinman noted that appellant presented with muscle tightness in the left lower to mid back, no radiation, paresthesia, or incontinence. She diagnosed back strain and returned appellant to work with restrictions. Dr. Kleinman noted no pain with palpation of the lower to mid back, bilateral upper and lower extremity motor strength was intact, and reflexes were intact. The Board has consistently held that contemporaneous evidence is entitled to greater probative value than later evidence.⁶ This report does not support

² *Jaja K. Asaramo*, 55 ECAB 200 (2004).

³ *Elizabeth H. Kramm (Leonard O. Kramm)*, 57 ECAB 117 (2005).

⁴ *Leslie C. Moore*, 52 ECAB 132 (2000).

⁵ *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).

⁶ *See Katherine A. Williamson*, 33 ECAB 1696 (1982); *Arthur N. Meyers*, 23 ECAB 111 (1971).

that the October 30, 2015 injury caused or aggravated any additional lumbar disc herniation, L4-5 foraminal impingement, L5 radiculopathy, sciatica desiccation of a disc, bulging discs at L2-3, or spinal stenosis at L2-3.

Appellant submitted reports from Dr. Ilizarov dated November 10 and December 14, 2015 and January 11, April 8, and 15, 2016. Dr. Ilizarov diagnosed left-sided low back pain since October 30, 2015, resolved, radiation of pain to the left lateral calf, left L5 radiculopathy, and L4-5 left paracentral caudal herniated nucleus pulposus confirmed by MRI scan. On April 8, 2016 she treated appellant for an exacerbation of left lumbar radiculopathy due to disc herniation. However, Dr. Ilizarov is merely repeating the history of injury as reported by appellant without providing her own opinion regarding these conditions were work related.⁷ Furthermore, she failed to provide a rationalized opinion regarding the causal relationship between appellant's conditions and the employment incident believed to have caused or contributed to such condition.⁸

On June 3, 2016 Dr. Ilizarov treated appellant for low back pain and sciatica localized to the left buttock and posterior thigh area. She noted a history of injury and appellant's initial treatment for left-sided low back pain and weakness which subsequently developed into radiating pain to the left lateral calf and left L5 radiculopathy. Dr. Ilizarov diagnosed lumbar back pain, lumbar disc herniation, and left lumbar radiculopathy which was causally related to the October 30, 2015 injury at work. The Board finds that, although Dr. Ilizarov supported causal relationship, she did not provide medical rationale explaining the basis of her conclusory opinion regarding the causal relationship between appellant's lumbar disc herniation and left L5 radiculopathy and the October 30, 2015 work injury.⁹ There is no medical explanation regarding how the moving of a refrigerator on October 30, 2015 caused or aggravated these conditions. Thus, this evidence is insufficient to meet appellant's burden of proof.

Likewise, the remainder of the medical evidence submitted did not specifically address how any mild degeneration and moderate left disc herniation, L4-5 minimal/mild left greater than right neural foraminal impingement, L5 radiculopathy, left side sciatica, mild-to-moderate desiccation of disc with mild diffuse bulging of annulus at L2-3, annular tear, and mild central spinal stenosis at the L2-3 level were due to the accepted work injury of October 30, 2015. Thus, these reports are insufficient to establish that any additional conditions are employment related.¹⁰

⁷ *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).

⁸ *See Jimmie H. Duckett*, *supra* note 5.

⁹ *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).

¹⁰ *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).

Appellant also submitted physical therapy notes. The Board has held that treatment notes signed by a physical therapist have no probative value as physical therapists are not considered physicians under FECA and is not competent to render a medical opinion.¹¹ Thus, this evidence is insufficient to meet appellant's burden of proof.

On appeal appellant asserts that OWCP improperly denied his request to expand his claim to include additional claimed conditions. He asserts that Dr. Ilizarov provided a rationalized medical opinion explaining how the above-named conditions were due to the accepted work injury of October 30, 2015. However, as noted above, the evidence submitted did not provide medical rationale from a physician explaining the causal relationship between appellant's diagnosed conditions and the accepted work injury of October 30, 2015.¹² Appellant also notes that OWCP's hearing representative references "*M.L.*" in his decision. The Board finds that *M.L.*,¹³ is a Board decision that was properly cited by the hearing representative in support of the proposition that a physician's conclusory statement in support of causal relationship of a condition to a work injury which is not fortified with rationale is entitled to little probative value.

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 that his additional claimed lumbar conditions were causally related to the October 30, 2015 employment incident.

¹¹ 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 the 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).

¹² See *T.M.*, *supra* note 9.

¹³ Docket No. 16-0240 (issued March 9, 2016).

ORDER

IT IS HEREBY ORDERED THAT the October 31, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 5, 2017
Washington, DC

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

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board