United States Department of Labor
Employees' Compensation Appeals Board

P.C., Appellant	)	
and	)	**Docket No. 17-1638**
	)	**Issued: April 18, 2018**
SMITHSONIAN INSTITUTE, NATIONAL ZOOLOGICAL PARK, Washington, DC, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 24, 2017 appellant, through counsel, filed a timely appeal from a March 8, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction to consider the merits of the case.[3]

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

[3] The Board notes that appellant submitted additional evidence after OWCP rendered its March 8, 2017 decision. The Board's jurisdiction is limited to reviewing the evidence that was before OWCP at the time of its final decision. Therefore the Board is precluded from reviewing this additional evidence for the first time on appeal. 20 C.F.R. § 501.2(c)(1).

ISSUE

The issue is whether appellant has met her burden of proof to establish intermittent periods of disability from January 16 through February 23, 2013 and from June 9, 2013 through January 9, 2016.

FACTUAL HISTORY

On August 14, 2011 appellant, then a 49-year-old utility systems operator, was injured when she slipped down wet stairs at the employing establishment. OWCP accepted her claim for sprain of the left hip and thigh, sprain of the sacroiliac ligament, and sprain of the lumbar back.

A September 23, 2011 lumbar spine magnetic resonance imaging (MRI) scan noted no evidence of disc herniation or protrusion, a disc bulge at L5-S1 with no spinal canal compromise, no evidence of a compression fracture, and no evidence of signal abnormality.

On November 1, 2011 Dr. David Dorin, a Board-certified orthopedic surgeon, found that appellant could perform light duty such as clerical-type activities for four hours daily beginning November 3, 2011. OWCP authorized compensation benefits from October 2 through 21, 2011. Appellant returned to light-duty work on November 6, 2011 working four hours a day.

Dr. Ricardo Pyfrom, a Board-certified orthopedic surgeon, completed a duty status report on November 1, 2013 and indicated that appellant was totally disabled from work from March 1 through June 10, 2013 due to lumbar strain. On November 1, 2013 he indicated that appellant could work on November 1, 2013.

Appellant filed a claim for compensation (Form CA-7) for leave without pay (LWOP) for the period February 24 to June 9, 2013.

In a November 19, 2013 letter, OWCP noted that appellant returned to light-duty work on November 3, 2011 and requested that she provide factual and medical evidence in support of her claim for a recurrence of disability. It afforded her 30 days for a response.

Appellant responded to OWCP's development questionnaire and asserted that her back condition never resolved. Rather, it worsened in February 2013. Appellant provided a December 16, 2013 note from Dr. Pyfrom who indicated that appellant reported severe back pain which required her to go to an emergency room. On December 20, 2013 Dr. Pyfrom noted that appellant's low back pain and radicular symptoms escalated in intensity in February 2013. Appellant did not work from March 11 through June 10, 2013. He found spasms in the lower back with left lower extremity radiculopathy. Dr. Pyfrom diagnosed lumbar disc disease, lumbar strain, sacroiliac joint strain, and lumbar radiculopathy. He provided work restrictions and noted that appellant spontaneously developed radiculopathy with paresthesias in her legs.

By decision dated January 9, 2014, OWCP denied appellant's wage-loss claim for the period February 24 to June 9, 2013. Appellant requested an oral hearing before an OWCP hearing representative. She returned to light-duty work on January 27, 2014. Dr. Pyfrom indicated that appellant could perform light-duty work on May 20, 2014.

Appellant testified during the oral hearing held on August 5, 2014, noting that she did not initially return to full duty work after her August 14, 2011 employment injury. She reported that she stopped work because her back pain had increased and her doctor found she was totally disabled until June 10, 2013 when she returned to light-duty work. At the time of the hearing, appellant had returned to work eight hours a day with restrictions.

On August 19, 2014 Dr. Pyfrom noted that appellant's back condition worsened on March 11, 2013 and she did not work until June 10, 2013. Appellant reported that her back and leg pain progressively worsened. He examined her on July 29, 2013. Dr. Pyfrom noted treating appellant on July 24, 2012, July 29, November 1, and December 16, 2013, January 27, April 8, May 20, and July 22, 2014. He provided an October 2, 2012 duty status report (Form CA-17) and notes dated July 24, 2012 and September 9, 2014.

By decision dated October 23, 2014, OWCP's hearing representative found that appellant had not provided medical evidence establishing that she was totally disabled from February 24 through June 9, 2013.

Dr. Pyfrom examined appellant on October 20, 2014 and March 20, 2015 noting that she was performing light-duty work, but still experiencing pain. He reviewed appellant's lumbar MRI scan on March 20, 2015 and found a central disc herniation at L5-S1 as well as bilateral foraminal stenosis. Dr. Pyfrom noted that appellant could not really work and took several days off because of the leg pain.

On May 27, 2015 appellant requested reconsideration of the October 23, 2014 decision of OWCP's hearing representative. Dr. Pyfrom completed a disability certificate on April 30, 2015 and opined that appellant was totally disabled from March 11, 2013 through June 10, 2015 due to lumbar disc disease with radiculopathy. On the same date, he found that appellant was still having pain while walking up and down stairs.

By decision dated September 3, 2015, OWCP denied modification of the October 23, 2014 decision.[4]

Dr. Pyfrom completed a note on August 20, 2015 and indicated that appellant continued to experience intermittent periods of back pain with tingling in the left foot. He found muscle spasms and noted that appellant was performing full-time light-duty work. On October 1, 2015 Dr. Pyfrom completed notes as well as a duty status report (Form CA-17) and found that appellant could perform full-time light duty with restrictions.

The employing establishment provided appellant with a full-time light-duty job assignment on November 25, 2015. Dr. Pyfrom saw appellant on December 17, 2015 and noted that she was trying to work. He advised that she could work light duty.

[4] As more than 180 days has elapsed from the date of that decision to the filing of this appeal, the Board does not have jurisdiction over the September 3, 2015 decision. 20 C.F.R. § 501.3(e).

On January 14, 2016 appellant filed an additional claim for compensation (Form CA-7) for the period October 2, 2011 through January 9, 2016. The employing establishment provided time analysis forms for each two-week period covering the claimed periods of intermittent disability.

In support of her claims for total disability, appellant submitted a July 29, 2013 disability certificate from Dr. Pyfrom which indicated that appellant was totally disabled from July 29 through August 5, 2013. Dr. Pyfrom completed an additional disability certificate on November 1, 2013 which indicated that appellant could perform light duty.

Dr. Pyfrom completed a report on January 27, 2014 and indicated that appellant could not work from March 11 through June 10, 2013 due to her increased back pain due to her August 14, 2011 employment injury. In a report dated December 18, 2015, Dr. Pyfrom diagnosed lumbar disc disease, facet arthropathy, and left-sided lumbar radiculopathy and noted her August 14, 2011 employment injury. He noted that appellant had been on light-duty work restrictions from December 1, 2011. Dr. Pyfrom further noted, "She also had to miss several days of work and take leave of absence due to her pain." He reviewed appellant's MRI scan dated February 11, 2015 and found L4-5 and L5-S1 disc disease with lateral disc herniation and bilateral foraminal stenosis at L4-5 and L5-S1. Dr. Pyfrom opined that appellant's lumbar spine condition was a direct result of the August 14, 2011 fall.

On January 13, 2016 the employing establishment provided appellant with a limited-duty assignment which she accepted.

In a January 21, 2016 letter, OWCP requested additional factual and medical information in support of her claim for compensation from October 2, 2011 through January 9, 2016.[5]

Dr. Pyfrom, in a February 2, 2016 report, advised that the August 14, 2011 work injury resulted in muscle and ligament injuries to her back sacroiliac joint, and lumbar discs. He found that the bulging disc irritated her sciatic nerve. Dr. Pyfrom diagnosed lumbar disc disease with radiculopathy which was the result of progression of her disc injury with time and ongoing use of her back to stand, walk, lift, and carry. He explained, "Axial loads applied constantly across the injury disc level developed degenerative changes with bone end plate developing marginal osteophytes and the supporting facets have hypertrophied to provide support [for] the disc, which as a shock absorber, is no longer able to function as effectively." Dr. Pyfrom noted that the thickened facet joint were encroaching on the exiting nerve roots of L4-5 and L5-S1. He noted that degeneration over time from her August 14, 2011 injury was the result of inadequate intervention to address the initial sprain. He reported, "Her current condition is the effect of bone hypertrophy occurring as a natural body response to the disc injury."

By decision dated March 2, 2016, OWCP denied appellant's claim for compensation for the period October 2, 2011 through January 9, 2016. On March 10, 2016 appellant requested reconsideration of this decision.

On April 4, 2016 the employing establishment provided appellant with a light-duty job offer. In an April 12, 2016 report, Dr. Pyfrom diagnosed intervertebral disc disorders with

[5] OWCP noted that the claimed period of disability from February 24 to June 9, 2013 had been formally denied and would not be readdressed.

radiculopathy in the lumbosacral region. He noted that appellant was working with light-duty restrictions, but utilizing sick leave due to too much back pain.

By decision dated June 7, 2016, OWCP denied modification of its March 2, 2016 decision. It found that Dr. Pyfrom did not address appellant's specific dates of total disability and that he generally supported her ability to perform light-duty work.

OWCP received additional evidence. In a May 31, 2016 report, Dr. Pyfrom diagnosed intervertebral disc disorders with radiculopathy in the lumbosacral region. He also diagnosed spondylosis with radiculopathy in the lumbar region. In disability certificates dated May 6, 31, and July 11, 2016, Dr. Pyfrom found that appellant was totally disabled beginning May 2, 2016. In a note dated July 11, 2016, he relayed appellant's continued symptoms of lower back pain and radicular symptoms of burning, tingling, and numbness in her left leg and thigh. Dr. Pyfrom diagnosed intervertebral disc disorders with radiculopathy in the lumbosacral regions and other spondylosis with radiculopathy lumbar region.

Also received was a June 2, 2016 proposal from the employing establishment to separate appellant from her position as she was unable to perform the essential duties required and as there was no permanent light-duty work available for her.

On August 12, 2016 Dr. Pyfrom noted examining appellant on August 11, 2016. He described the August 14, 2011 injury and reviewed initial records including the September 23, 2011 MRI scan. Dr. Pyfrom noted first examining appellant on December 1, 2011 due to persisting low back pain with radiation from the left sacroiliac joint to the left leg and toes of her left foot. A February 11, 2015 MRI scan showed a moderate disc bulge at L4-5 with significant hypertrophy of the ligamentum flavum and resulting severe canal stenosis with mild bilateral foraminal narrowing due to the disc bulge. The L5-S1 level also had a moderate disc bulge with moderate-to-severe left foraminal narrowing. Dr. Pyfrom found a thickened lumped appearance of the nerve roots consistent with arachnoiditis. He examined appellant and diagnosed lumbar strain, sequelae of lumbar contusion, and intervertebral disc herniation of the lumbosacral spine with radiculopathy. Dr. Pyfrom reviewed his treatment notes relating the progression of appellant's symptoms. He explained the changes in appellant's lumbar spine noting that the September 23, 2011 MRI scan showed a bulging disc at L5-S1 and that the disc was more compressed at the time of the February 11, 2015 MRI scan "due to hypertrophic changes of the ligamentum flavum and hypertrophy of the facet joints in combination with intervertebral disc bulge." Dr. Pyfrom noted, "The thickening of ligamentum flavum and the enlargement of the facet joints are changes occurring to the disc over the time of four years postinjury to lumbar spine ligaments. Instability at these disc levels were met with the body's response to try to stabilize the injured area with thickening of the ligamentum flavum and to reduce pressure on these injured disc levels by overgrowing the size of the facet joints to increase the surface area thus causing joint reaction forces to decrease." Dr. Pyfrom noted similar changes at L4-5. Regarding findings consistent with arachnoiditis, he advised that, "Arachnoiditis is often a result of direct contusion of the spine's bony elements also in contusion of the epidural veins around the nerve roots. The findings are strongly suggestive that her fall on August 14, 2011 resulted in a significant contusion of the spinal nerve roots in the lower lumbar spine that occurred when her back hit the steps, but were not seen on the early MRI scan due to the short time after the injury and the lack of contrast in the initial study." Dr. Pyfrom found that appellant was totally disabled.

Dr. Pyfrom examined appellant on October 27, 2016. He found that sensation to light touch was decreased on the left in the lateral thigh, calf, and foot. Dr. Pyfrom diagnosed intervertebral disc disorders with radiculopathy in the lumbosacral region.

Counsel requested reconsideration of the June 7, 2016 decision on December 8, 2016. In support of this request, he resubmitted Dr. Pyfrom's August 12, 2016 report. In a note dated December 5, 2016, Dr. Pyfrom repeated his diagnosis of intervertebral disc disorders with radiculopathy in the lumbosacral region. He found that appellant was totally disabled. Dr. Pyfrom submitted a similar note dated February 13, 2017.

By decision dated March 8, 2017, OWCP found that appellant had not submitted medical evidence establishing that she was unable to perform her light-duty work on the dates in question.

LEGAL PRECEDENT

An employee seeking benefits under FECA[6] has the burden to establish the essential elements of his or her claim, including that any disability or specific condition for which compensation is claimed is causally related to the employment injury.[7] The term disability is defined as the incapacity because of an employment injury to earn the wages the employee was receiving at the time of the injury, *i.e.*, a physical impairment resulting in loss of wage-earning capacity.[8]

Whether a particular injury causes an employee to be disabled for employment and the duration of that disability are medical issues which must be proven by a preponderance of the reliable, probative, and substantial medical evidence.[9] Findings on examination are generally needed to support a physician's opinion that an employee is disabled from work. When a physician's statements regarding an employee's ability to work consist only of repetition of the employee's complaints, without objective findings of disability being shown, the physician has not presented a medical opinion on the issue of disability or a basis for payment of compensation.[10] The Board will not require OWCP to pay compensation for disability in the absence of any medical evidence directly 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.[11]

When an employee, who is disabled from the job he or she held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence of record establish that he or she can perform the light-duty position, the employee has the burden of proof

[6] *Supra* note 2.

[7] *G.T.*, 59 ECAB 447 (2008); *Kathryn Haggerty*, 45 ECAB 383 (1994); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[8] 20 C.F.R. § 10.5(f); *see, e.g., Cheryl L. Decavitch*, 50 ECAB 397 (1999) (where appellant had an injury but no loss of wage-earning capacity).

[9] *See Fereidoon Kharabi*, 52 ECAB 291 (2001).

[10] *Id.*

[11] *Id.*

to establish by the weight of the reliable, probative, and substantial evidence a recurrence of total disability and show that she cannot perform such light duty. As part of this burden, the employee must show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the light-duty requirements.[12]

Causal relationship is a medical issue and the medical evidence required to establish causal relationship is rationalized medical evidence.[13] Rationalized medical evidence is medical evidence which includes a physician's detailed medical opinion on the issue of whether there is causal relationship between the claimant's diagnosed condition and the implicated employment factors. 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 factors identified by the claimant.[14] Neither the fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[15]

ANALYSIS

The Board finds the case not in posture for a decision.

In support of her claimed periods of total disability resulting in usage of LWOP, appellant has submitted a series of reports from Dr. Pyfrom. On December 20, 2013 Dr. Pyfrom noted an escalation of appellant's injury-related condition and diagnosed lumbar disc disease, lumbar strain, sacroiliac strain, and lumbar radiculopathy. He opined that appellant had a recurrence of her work-related injury. On December 18, 2015 Dr. Pyfrom noted appellant's status and diagnoses. He concluded that appellant's lumbar condition was a direct result of the August 14, 2011 fall. In his February 2, 2016 report, Dr. Pyfrom also noted appellant's history and opined that the August 14, 2011 injury resulted in muscle and ligament injuries to her back sacroiliac joint, and lumbar discs. He diagnosed lumbar disc disease with radiculopathy and attributed this condition to progression of her disc injury with time and ongoing use of her back to stand, walk, lift, and carry. Dr. Pyfrom provided medical reasoning noting, "Axial loads applied constantly across the injury disc level developed degenerative changes with bone end plate developing marginal osteophytes and the supporting facets have hypertrophied to provide support [for] the disc, which as a shock absorber, is no longer able to function as effectively." He also noted that the thickened facet joint were encroaching on the exiting nerve roots of L4-5 and L5-S1. Dr. Pyfrom reported, "Her current condition is the effect of bone hypertrophy occurring as a natural body response to the disc injury."

Furthermore, on August 12, 2016, Dr. Pyfrom reviewed appellant's history, including comparing appellant's initial September 23, 2011 MRI scan with the February 11, 2015 MRI scan. He related his history of treatment and the progression of appellant's symptoms. Dr. Pyfrom found

[12] *Terry R. Hedman*, 38 ECAB 222 (1986).

[13] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

[14] *Leslie C. Moore*, 52 ECAB 132 (2000).

[15] *Dennis M. Mascarenas*, 49 ECAB 215 (1997); *T.M.*, Docket No. 16-1262 (issued January 11, 2017).

thickened lumped appearance of the nerve roots consistent with arachnoiditis on the MRI scan. He examined appellant and diagnosed lumbar strain, sequelae of lumbar contusion, and intervertebral disc herniation of the lumbosacral spine with radiculopathy. Dr. Pyfrom explained the changes in appellant's lumbar spine noting that the bulging disc at L5-S1 was more compressed at the time of the February 11, 2015 MRI scan "due to hypertrophic changes of the ligamentum flavum and hypertrophy of the facet joints in combination with intervertebral disc bulge." He noted, "The thickening of ligamentum flavum and the enlargement of the facet joints are changes occurring to the disc over the time of four years postinjury to lumbar spine ligaments. Instability at these disc levels were met with the body's response to try to stabilize the injured area with thickening of the ligamentum flavum and to reduce pressure on these injured disc levels by overgrowing the size of the facet joints to increase the surface area thus causing joint reaction forces to decrease." Dr. Pyfrom noted similar changes at L4-5. Regarding arachnoiditis, he explained that arachnoiditis often resulted from a "direct contusion of the spine's bony elements also in contusion of the epidural veins around the nerve roots." Dr. Pyfrom opined that "the findings are strongly suggestive that her fall on August 14, 2011 resulted in a significant contusion of the spinal nerve roots in the lower lumbar spine that occurred when her back hit the steps, but were not seen on the early MRI scan due to the short time after the injury and the lack of contrast in the initial study." He found that appellant was totally disabled.

These reports contain a history of injury, diagnosis, and an opinion that appellant's accepted conditions spontaneously worsened. While Dr. Pyfrom's reports are insufficient to meet appellant's burden of proof, they do raise an uncontroverted inference of causal relation between appellant's accepted employment incident on August 14, 2011 and an exacerbation of her diagnosed condition to include diagnosed lumbar strain, sequelae of lumbar contusion, and intervertebral disc herniation of the lumbosacral spine with radiculopathy as well as arachnoiditis and are sufficient to require OWCP to undertake further development of appellant's claim.[16]

The issue remains as to whether appellant was disabled from January 16 through February 24, 2013 and from June 9, 2013 through January 9, 2016 as a result of the August 14, 2011 employment injury.[17]

Thus, the Board finds that further development is required to determine whether appellant was disabled from work due to the August 14, 2011 employment injury.[18] On remand, OWCP should prepare a statement of accepted facts and refer appellant to an appropriate Board-certified specialist for a second opinion examination and rationalized opinion as to whether appellant's injuries were causally related to the August 14, 2011 work injury. Following any necessary further development, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for a decision.

[16] *John J. Carlone*, 41 ECAB 354, 358-60 (1989).

[17] *D.C.*, Docket No. 14-11312 (issued May 6, 2015); *E.P.*, Docket No. 14-1298 (issued January 7, 2015).

[18] *D.C.*, *id.*; *K.M.*, Docket No. 12-0726 (issued January 22, 2013); *D.N.*, Docket No. 09-651 (issued April 20, 2010).

ORDER

IT IS HEREBY ORDERED THAT the March 8, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further action consistent with this decision of the Board.

Issued: April 18, 2018
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