# United States Department of Labor
# Employees' Compensation Appeals Board

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| **O.R., Appellant** | ) | |
| **and** | ) | **Docket No. 20-1518** |
| | ) | **Issued: November 17, 2022** |
| **DEPARTMENT OF HOMELAND SECURITY, TRANSPORTATION SECURITY ADMINISTRATION, Miami, FL, Employer** | ) | |

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

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge
JAMES D. McGINLEY, Alternate Judge

### ***JURISDICTION***

On August 14, 2020 appellant filed a timely appeal from an August 3, 2020 merit decision of the Office of Workers' Compensation Programs (OWCP).[1] Pursuant to the Federal Employees' Compensation Act[2] (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 a lumbar condition causally related to the accepted December 9, 2014 employment incident.

[1] Appellant also timely appealed from decisions issued under other OWCP file numbers. The Board will adjudicate those appeals separately.

[2] 5 U.S.C. § 8101 *et seq*.

## ***FACTUAL HISTORY***

This case has been previously before the Board.[3] The facts and circumstances as set forth in the Board's prior order are incorporated herein by reference. The relevant facts are set forth below.

On October 2, 2018 appellant, then a 35-year-old transportation security officer, filed a traumatic injury claim (Form CA-1) alleging that on December 9, 2014 he aggravated his lumbar spine as a result of repetitively lifting, dragging and pushing oversized and heavy bags while in the performance of duty.[4] He explained that his workload was increased in the baggage area during the holiday season. Appellant did not stop work.

In a January 2, 2014 medical note, Dr. Katzman, a Board-certified orthopedic surgeon, recommended light-duty desk work. He diagnosed right leg sciatica and a herniated disc at L5-S1.

In a February 26, 2014 medical report, Dr. Jonathan Hyde, a Board-certified orthopedic surgeon, diagnosed lumbosacral disc degeneration and thoracic/lumbosacral neuritis/radiculitis and recommended that appellant undergo an electromyography (EMG) scan for further evaluation. In a medical form of even date, he provided work restrictions. In a subsequent March 14, 2014 medical report, Dr. Hyde scheduled appellant to undergo a laminectomy procedure to treat his condition.

In an April 1, 2014 operative report, Dr. Hyde performed a right inferior L5 hemilaminectomy, a right S1 anterior hemilaminectomy, a S1 foraminectomy, a partial facetectomy for L5 nerve root, and a lysis of adhesions with excision of disc herniation at L5-S1 to treat appellant's condition.

In an April 15, 2014 medical report, Diana Martinez, a physician assistant, evaluated appellant two weeks after his surgical procedure and noted his progression with healing. She held him off of work and recommended that he follow up with Dr. Hyde in one month.

In a subsequent May 16, 2014 medical report, Dr. Hyde evaluated appellant following his surgical procedure and noted his improved condition. In a June 20, 2014 medical report, he referred appellant to physical therapy.

[3] *Order Granting Motion to Reverse*, Docket No. 19-1234 (issued June 23, 2020).

[4] The Board notes that appellant has a previously accepted July 2, 2013 traumatic injury claim for a lumbar back sprain and herniated lumbar disc at L5-S1 under OWCP File No. xxxxxx033. Appellant also previously filed an occupational disease claim (Form CA-2) for an emotional condition under OWCP File No. xxxxxx667, which was formally denied on July 20, 2015. On May 12, 2017 appellant filed a traumatic injury claim alleging that he injured his low back and right knee on August 6, 2014 under OWCP File No. xxxxxx404. OWCP formally denied this claim on July 9, 2018. On February 8, 2018 it accepted a subsequent traumatic injury claim for aggravation of the L5-S1 herniated lumbar disc under OWCP File No. xxxxxx403.

Appellant submitted physical therapy reports dated from June 24 to August 11, 2014. In a July 18, 2014 medical report, Ms. Martinez noted appellant's improvement with physical therapy and recommended that he continue to work limited duty.

In an August 22, 2014 medical report, Dr. Hyde evaluated appellant after an April 1, 2014 lumbar laminectomy/discectomy procedure. In his August 22, 2014 report, he determined that appellant had seven percent permanent impairment based on the *Uniform Permanent Impairment Rating Guide*.

In an October 6, 2014 medical form, Dr. Hyde determined that appellant reached maximum medical improvement (MMI) on August 22, 2014 and determined that he had seven percent permanent impairment of his spine based on the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[5]

In a December 9, 2014 form report, appellant asserted that he sustained an emotional condition directly related to the chronic lower back pain and right leg cramping after demanding days of heavy lifting at work. He related that the pain made it difficult for him to sleep and that his supervisor was harassing him with false accusations.

In medical reports dated December 10, 2014 and January 23, 2015, appellant informed Dr. Hyde that he had returned to work, but still experienced pain in his right leg. Dr. Hyde referred him for another magnetic resonance imaging (MRI) scan for further evaluation of his symptoms.

In medical reports dated from April 6 to 14, 2015, Dr. Manuel Carril, a chiropractor, evaluated appellant for right knee pain. Appellant informed him that he injured his right knee while rehabilitating from his April 1, 2014 surgical procedure. Dr. Carril diagnosed a knee sprain and knee joint pain and performed a mobilizing spinal adjustment.

In an April 23, 2015 diagnostic report, Dr. Michael Thorpe, a Board-certified diagnostic radiologist, performed an MRI scan of appellant's right knee, finding a 1.2 centimeter cartilage defect in the trochlea and joint effusion.

In an October 5, 2015 medical report, Dr. Jesse Shaw, a Board-certified orthopedic surgeon, reviewed appellant's history of medical treatment relating to the April 22, 2013 employment injury. He diagnosed right quadriceps muscle weakness and atrophy and opined that the condition was due to appellant's April 22, 2013 lumbar spine injury that led to non-physiological altered gait mechanics and his right knee symptoms.

In a November 6, 2015 medical report, Dr. Hyde diagnosed other intervertebral disc displacement, lumbar region. He observed that appellant was evaluated by Dr. Shaw for his right knee symptoms and noted that he would defer to her findings for any impairment or restrictions.

[5] A.M.A., *Guides* (6th ed. 2009).

In a November 13, 2015 medical report, Dr. Hyde reviewed a November 12, 2015 MRI scan of appellant's lumbar spine and opined that his right knee pain was not a direct consequence of his herniated disc or spine surgery.

In medical reports dated February 15 and March 30, 2016 medical report, Dr. Shaw diagnosed unspecified right joint effusion, unspecified right muscle wasting and atrophy, right muscle weakness, a sprain of the right knee and lumbar region radiculopathy. She ordered another MRI scan of his right knee.

In a March 31, 2016 diagnostic report, Dr. Jonathan Luchs, a Board-certified radiologist, performed an MRI scan of appellant's right knee, finding a joint effusion and no definitive internal derangement or fracture.

In an April 5, 2016 medical report, Dr. Samy Bishai, a Board-certified orthopedic surgeon, reviewed appellant's history of lower back and right knee pain beginning after the April 22, 2013 employment incident. He explained that appellant aggravated his condition on May 14, 2013 when he was pulling luggage. On review of appellant's medical records and evaluation Dr. Bishai diagnosed a herniated lumbar disc at L5-S1 with right-sided radiculopathy, L5 nerve root and lysis of adhesions with excisions of disc herniation at L5-S1 and slight atrophy of the vastus medialis right knee joint. She opined that appellant's vastus medialis atrophy was not related to his right knee joint, but rather related to his May 14, 2013 back injury.

In medical reports dated from April 15 to July 19, 2016, Dr. Mark Fishman, a Board-certified physiatrist, diagnosed lumbar disc degeneration, lumbosacral spondylosis, lumbar stenosis, lumbosacral post-laminectomy syndrome and lumbar myofascial pain syndrome. He advised that appellant complete his functional capacity evaluation (FCE) and continue his home exercises.

In a March 3, 2017 medical report, Dr. Caio Goncalves, Board-certified in emergency medicine, evaluated appellant for his complaints of low back pain. Appellant informed him that the onset of his pain began two days prior at work when he was lifting and bending. Dr. Goncalves diagnosed a back strain and provided a back strain information sheet.

In a March 27, 2017 medical report, Dr. Katzman reviewed appellant's history of injury in relation to his April 22, 2013 employment injury. On review of diagnostic studies and evaluation, he diagnosed low back pain and radicular right leg radiculitis and recommended work restrictions for appellant to follow.

In an April 4, 2017 diagnostic report, Dr. Brian Young, a Board-certified radiologist, performed an MRI scan of appellant's lumbar spine and diagnosed a T12-L1 disc herniation, L3-4 and L4-5 disc bulges with mild central stenosis and a L5-S1 disc bulge noted with enhancing soft tissue off the posterior disc space margin.

In an April 10, 2017 medical report, Dr. Katzman reviewed appellant's MRI scan and diagnosed low back pain and disc herniation at L5-S1. He provided updated work restrictions.

In a June 14, 2017 medical report, Dr. Bishai clarified her April 5, 2016 medical opinion, explaining that appellant's May 14, 2013 injury was an aggravation of his April 22, 2013 injury

and caused the development of his radiculopathy. She noted that the atrophy to the vastus medialis was related to the compression of a nerve root secondary to his back condition, and not related to his right knee injury as a primary injury. Dr. Bishai further noted appellant's employment duties and opined that his constant kneeling to check oversized luggage may have contributed to his right knee problems.

In a June 16, 2017 medical report, Dr. Katzman diagnosed a residual herniated disc at L5-S1 and residual back pain status post lumbar laminectomy. He opined that appellant could return to work with modified duty.

In an October 26, 2017 medical report, Dr. Sami Zaki, Board-certified in family medicine, evaluated appellant for back pain, which he noted began the day prior while he was performing house chores. He informed her that his chronic back pain first began in 2013 while lifting at work and that he underwent surgery in 2014 to treat the symptoms related to his condition. Dr. Zaki diagnosed chronic back pain with an acute exacerbation.

In an undated statement, Dr. Shaw reviewed the history of appellant's physical therapy reports in which he began to feel pain in his right knee after performing lunges. He opined that appellant would not have been suited to perform his job functions as of October 5, 2015 and stated that proper restrictions were needed in order for his knee to heal correctly.

In medical reports dated November 2 and December 7, 2017, Dr. Katzman evaluated appellant for low back pain and left buttock pain and noted his previous diagnosis of a disc herniation in relation to an April 22, 2013 employment injury. He diagnosed low back pain, lumbar radiculitis and left leg sciatica/gluteal pain. Dr. Katzman advised that appellant undergo physical therapy and recommended work restrictions for him to follow.

In a January 16, 2018 medical report, Dr. Christopher Brown, a Board-certified orthopedic surgeon, noted that he first injured his back in the April 2013 employment incident and later aggravated the injury in a subsequent May 13, 2013 injury when he was pushing luggage at work. He stated that the disc herniation was caused by the April 22, 2013 employment injury.

Appellant submitted physical therapy reports dated from January 4 to March 2, 2018 in which he was treated for his complaints of low back pain.

In a March 5, 2018 medical report, Dr. Katzman noted that the pain in appellant's left-sided back and buttock had significantly improved. He observed that an updated MRI scan demonstrated worsening disc desiccation and collapse at the L5-S1 segment with epidural fibrosis, junctional facet synovitis and foraminal narrowing. Dr. Katzman diagnosed low back pain, lumbar disc desiccation, degeneration and disc displacement at the L5-S1 segment with bilateral foraminal narrowing, L4-L5 facet synovitis and foraminal narrowing and left lumbar radiculitis. He opined that, due to appellant's April 22, 2013 disc injury, he underwent a degenerative process that is worsening at the L5-S1 segment. Dr. Katzman explained that, due to the collapse and worsening degenerative changes, his injury caused degenerative cascade to the disc at L5-S1. He offered that due to a loss of mobility at the desiccated disc additional stress was placed on the adjacent segment, causing lumbar facet synovitis.

In an April 12, 2018 medical report, Dr. Clinton Bush, a Board-certified orthopedic surgeon serving as an OWCP second opinion physician, reviewed the statement of accepted facts (SOAF), history of injury, and medical evidence of record. He noted appellant's diagnoses of a disc herniation and right L5-S1 radiculopathy accepted as associated with the April 22, 2013 employment injury. Dr. Bush explained that appellant's quadriceps muscle would not be affected by his spinal injury and opined that the medical evidence of record did not support that his right knee injury was related to his documented lumbar conditions.

In a May 10, 2018 medical report, Dr. Katzman reevaluated appellant for an April 22, 2013 work-related lifting injury. He noted that, as a result of his injury, appellant sustained an injury at the L5-S1 level and underwent a right-sided L5-S1 hemilaminectomy. Dr. Katzman then developed left-sided sciatica on October 26, 2017. He opined that the reaggravation of his back was directly related to the April 22, 2013 employment injury. Dr. Katzman noted that, in spite of physical therapy, appellant's left-sided sciatica and low back persisted and also reviewed an April 11, 2017 MRI scan of his lumbar spine that showed a worsening of the disc desiccation and collapse at L5-S1 segment with epidural fibrosis, junctional facet synovitis and foraminal narrowing. He diagnosed low back pain, lumbar disc desiccation, degeneration of disc displacement at L5-S1 with foraminal narrowing, L4-L5 facet synovitis and foraminal narrowing, and left lumbar radiculitis with left-sided lumbar sciatica.

In a May 18, 2018 diagnostic report, Dr. Alex Alonso, a Board-certified radiologist, performed an MRI scan of appellant's lumbosacral spine. He noted that appellant was experiencing lower back pain after an April 26, 2018 motor vehicle accident. Dr. Alonso noted disc bulges at L3-4 and L4-5 and disc herniation at T12-L1 and L5-S1.

In a June 4, 2018 medical report, Dr. Liam McCarthy, a Board-certified physiatrist, evaluated appellant for lower back pain and reviewed the results of his May 18, 2018 MRI scan. He noted that appellant was scheduled to undergo an EMG scan; however, the nerve conduction machine was not functioning properly. Dr. McCarthy suggested that he return to his orthopedic surgeon to discuss treatment option.

In a June 18, 2018 diagnostic report, Dr. Alonso performed an MRI scan of appellant's lumbar spine, finding broad-based posterior disc bulges at L3-4 and L4-5 and disc herniation at T12-L1 and L5-S1.

In an August 1, 2018 medical report, appellant visited Dr. McCarthy seeking recommendations for his left T12-L1 disc herniation, L5-S1 disc herniation and left groin pain. Dr. McCarthy diagnosed low back pain, left groin pain and left T12-L1 disc herniation paracentrally without significant stenosis worsening at L5-S1.

In an August 3, 2018 medical report, Dr. Katzman reviewed appellant's treatment for low back pain and his recovery from a facet block he received on May 29, 2018. He noted the previous diagnosis of a strain of the midback and a low back strain and further diagnosed low back pain, status post left facet block, L5-S1.

In an August 21, 2018 e-mail, appellant provided a statement of facts relating to a December 10, 2014 employment injury. He explained that he underwent hemilaminectomy

surgery on April 1, 2014 and participated in physical therapy from June 24 to August 11, 2014. On August 25, 2014 appellant related that, despite never reaching the employing establishment's goal of lifting 70 pounds repeatedly and suffering a right knee injury, he was told he reached MMI and was cleared to return to work full duty. On December 10, 2014 he suffered a lumbar sprain due to an increased workload of frequent bending, stooping, kneeling, dragging and lifting items that weighed up to 70 pounds. The injury was never reviewed by the physician who performed his surgery or reported to OWCP.[6] On July 6, 2016 appellant was removed from work after being denied reasonable accommodations and being unable to perform the full scope of his employment duties. He concluded by recounting the history of treatment he received through OWCP for his pain related to his lumbar condition.

In medical reports dated August 17 and August 24, 2018, Dr. Katzman recounted appellant's history of treatment related to an April 22, 2013 back injury and a subsequent laminectomy and discectomy at L5-S1, as well as lidocaine injections, to treat his injury. On evaluation he diagnosed facetogenic back pain, L5-S1 facet disease and lumbar disc displacement at L5-S1. Dr. Katzman reviewed past documentation from appellant and opined that his pain was facetogenic and was not new, but recurrent. He recommended permanent work restrictions for appellant to follow.

Appellant submitted physical therapy reports dated from September 18 to 28, 2018 in which Cynthia Gonzalez, a physical therapist, evaluated appellant for his continuing lumbar pain and recommended that he undergo three weeks of physical therapy.

In a development letter dated October 9, 2018, OWCP made note of appellant's four previous claims.[7] It provided a questionnaire for his completion seeking information about the claimed employment incident alleged to have caused or contributed to his medical condition and requested a medical report from his attending physician explaining how and why his federal employment caused, contributed to, or aggravated his medical condition. OWCP afforded appellant 30 days to submit the requested information.

In a March 7, 2016 medical report, Dr. Stephen Wender, a Board-certified arthroscopic surgeon, evaluated appellant for low back pain related to an April 22, 2013 employment injury in which he was required to repeatedly lift suitcases weighing up to 70 pounds. He recounted appellant's history of medical treatment, including physical therapy and an April 1, 2014 surgical procedure to treat his diagnosed lumbar conditions. On examination and review of appellant's medical and diagnostic reports, Dr. Wender opined that he had reached MMI and sustained 10 percent permanent impairment.

In a May 29, 2018 medical report, Dr. David Arroyo, Board-certified in family medicine, evaluated appellant for back pain and lumbar pain that began four days prior when he was lifting approximately 25-pound boxes of paper at work. He diagnosed a strain of the mid-back and a low

[6] Appellant explained that, shortly after the December 9, 2014 employment injury, he was suspended and wrongfully terminated from employment after filing a discrimination complaint against a supervisor who refused to allow him to report his injury. His termination was eventually overturned, and he was reinstated on August 27, 2015.

[7] *Supra* note 4.

back strain and provided a series of informational fact sheets on back strains with instructions for stretches to perform during home care to treat appellant's symptoms.

In physical therapy reports dated from October 1 to 16, 2018, Ms. Gonzalez discharged appellant from physical therapy treatment.

In response to OWCP's questionnaire, appellant submitted a November 26, 2018 statement where he explained that his injury occurred at the baggage area and after his injury he went to the emergency room as he could not bend down or pick up items.

In a medical report of even date, Dominick Caracciolo, a physician assistant, evaluated appellant after the completion of his physical therapy plan of care for his low back pain. He diagnosed low back pain, myofascial tenderness, a lumbar disc displacement at L5-S1 and facetogenic myofascial pain.

By decision dated December 12, 2018, OWCP denied appellant's traumatic injury claim, finding that it had not been filed within the applicable time limits of 5 U.S.C. § 8122. It noted that his claimed injury occurred on December 9, 2014 and he did not file his claim until October 2, 2018, which was more than three years later.

On December 17, 2018 appellant requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review. In an attached letter of even date, he asserted that his claim was timely filed and included a signed December 12, 2014 acknowledgment from his immediate supervisor showing that he reported an injury on December 10, 2014. Appellant also argued that his claim was mistakenly treated as a recurrence of a previously filed claim and that this misconception interfered with the proper resolution of his claim.

Appellant also submitted a December 4, 2015 affidavit from an Equal Employment Opportunity (EEO) complaint he filed alleging harassment and discrimination based on a disability from his supervisor.

In a March 27, 2017 medical report, Dr. Katzman reviewed appellant's history of treatment for his lumbar condition including Dr. Hyde's April 1, 2014 surgical procedure performed to treat his condition. He diagnosed low back pain, radicular right leg radiculitis status post right L5-S1 hemilaminectomy with partial facetectomy at L5 and lysis of adhesins with excision of disc herniation at L5-S1.

In a February 11, 2019 medical report, Dr. Katzman evaluated appellant during a follow-up appointment with regard to his April 22, 2013 employment injury. He diagnosed low back pain, myofascial tenderness, a lumbar disc displacement at L5-S1 and facetogenic back pain.

A telephonic hearing was held on March 18, 2019. Appellant alleged that his claim examiner mistakenly kept his most recent injury as a recurrence under OWCP File No. xxxxxx033 instead of treating his injury as a new claim. He also explained that he completed a separate form for his alleged December 9, 2014 injury and left it with the employing establishment.

In a March 25, 2019 letter, appellant attached a copy of his December 9, 2014 employee statement to his workplace injury form and explained that, after his supervisor refused to complete

the proper Form CA-1 for his December 9, 2014 injury, he filed the harassment complaint against him and the employing establishment.

By decision dated April 25, 2019, OWCP's hearing representative affirmed the December 12, 2018 decision.

On May 14, 2019 appellant appealed to the Board.

In medical reports dated June 27 and August 2, 2019, Dr. Katzman evaluated appellant for left-sided low back pain related to his April 22, 2013 employment injury. He diagnosed facetogenic low back pain, prescribed anti-inflammatory medication, and referred appellant to physical therapy to treat his condition.

In a motion to reverse dated December 4, 2019, the Director of OWCP requested that the Board reverse OWCP's April 25, 2019 decision and find that appellant's claim was timely filed. He reasoned that appellant submitted sufficient evidence demonstrating that his supervisors had reasonable notice that he had an on-the-job injury and, thus, satisfying the test for actual knowledge. The Director of OWCP asserted that, given that this information was received by appellant's supervisors within the 30-day statutory time frame, appellant's claim was timely filed.

In an April 28, 2020 medical report, Dr. Katzman evaluated appellant for left-sided back pain in relation to his April 22, 2013 employment injury. He diagnosed left-sided low back pain and prescribed additional medications for appellant to use.

By order dated June 23, 2020,[8] the Board granted the Director of OWCP's motion and reversed OWCP's April 25, 2019 decision, finding that appellant's claim was timely filed. It also ordered that the present case file be administratively combined with appellant's previous claims in OWCP File Nos. xxxxxx033, xxxxxx403 and xxxxxx404.

By decision dated August 3, 2020, OWCP denied appellant's traumatic injury claim, finding that the medical evidence of record was insufficient to establish that his diagnosed lumbar condition was causally related to the accepted December 9, 2014 employment 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 timely filed within the applicable time limitation period of FECA,[9] that an injury was sustained in the performance of duty, as alleged, and that any disability or medical condition for which compensation is claimed is causally related to the employment injury.[10] These are the essential elements of each and every

[8] *Supra* note 3.

[9] *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

[10] *L.S.*, Docket No. 19-1769 (issued July 10, 2020); *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

compensation claim, regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[11]

To determine if an employee has sustained a traumatic injury in the performance of duty, OWCP begins with an analysis of whether fact of injury has been established. Fact of injury consists of two components that must be considered in conjunction with one another. The first component is whether the employee actually experienced the employment incident that allegedly occurred.[12] The second component is whether the employment incident caused a personal injury.[13]

Causal relationship is a medical question that requires rationalized medical opinion evidence to resolve the issue.[14] A physician's opinion on whether there is causal relationship between the diagnosed condition and the implicated employment factor(s) must be based on a complete factual and medical background.[15] Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factor(s).[16]

In a case in which a preexisting condition involving the same part of the body is present and the issue of causal relationship, therefore, involves aggravation, acceleration, or precipitation, the physician must provide a rationalized medical opinion that differentiates between the effects of the work-related injury or disease and the preexisting condition.[17]

## ***ANALYSIS***

The Board finds that appellant has not met his burden of proof to establish a lumbar condition causally related to the accepted December 9, 2014 employment incident.

In his medical reports dated from March 27, 2017 to August 3, 2018, Dr. Katzman reviewed appellant's treatment for low back pain and provided work restrictions. He diagnosed low back pain, radicular right leg radiculitis status post right L5-S1 hemilaminectomy with partial facetectomy at L5 and lysis of adhesions with excision of disc herniation at L5-S1. The Board has held, however, that medical evidence that does not offer an opinion regarding the cause of an

[11] *K.M.*, Docket No. 15-1660 (issued September 16, 2016); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

[12] *B.P.*, Docket No. 16-1549 (issued January 18, 2017); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[13] *M.H.*, Docket No. 18-1737 (issued March 13, 2019); *John J. Carlone*, 41 ECAB 354 (1989).

[14] *T.H.*, 59 ECAB 388, 393 (2008); *Robert G. Morris*, 48 ECAB 238 (1996).

[15] *M.V.*, Docket No. 18-0884 (issued December 28, 2018).

[16] *B.C.*, Docket No. 20-0221 (issued July 10, 2020); *Leslie C. Moore*, 52 ECAB 132 (2000).

[17] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013); *K.R.*, Docket No. 21-0822 (issued June 28, 2022); *V.W.*, Docket No. 19-1537 (issued May 13, 2020); *N.C.*, Docket No. 19-1191 (issued December 19, 2019); *R.D.*, Docket No. 18-1551 (issued March 1, 2019).

employee's condition is of no probative value on the issue of causal relationship.[18] For this reason Dr. Katzman's medical reports are insufficient to meet appellant's burden of proof.

Similarly, in medical reports dated from December 10, 2014 to November 6, 2015, Dr. Hyde evaluated appellant for low back pain related to his diagnosis of intervertebral disc displacement, lumbar region. However, as stated above, medical evidence that does not offer an opinion regarding the cause of an employee's condition is of no probative value on the issue of causal relationship.[19] For this reason, Dr. Hyde's medical reports are insufficient to establish appellant's burden of proof.

Additionally, appellant submitted medical reports dated from April 15, 2016 to August 1, 2018 where Drs. Fishman and McCarthy provided treatment relating to diagnoses of lumbar disc degeneration, lumbosacral spondylosis, lumbar stenosis, lumbosacral post-laminectomy syndrome, lumbar myofascial pain syndrome, low back pain, left groin pain and left T12-L1 disc herniation paracentrally without significant stenosis worsening at L5-S1. As Drs. Fishman and McCarthy did not offer an opinion regarding the cause of appellant's condition, their medical evidence is also of no probative value on the issue of causal relationship.[20]

Appellant submitted diagnostic reports dated April 4, 2017 and June 18, 2018 from Drs. Young and Alonso, respectively. The Board has held, however, that diagnostic test reports, standing alone, lack probative value as they do not provide an opinion on causal relationship between an employment incident and a diagnosed condition.[21] For this reason, the diagnostic reports are insufficient to meet appellant's burden of proof.

Appellant also provided physical therapy reports dated from January 4 to October 16, 2018 signed by a physical therapist, and a November 26, 2018 medical report signed by a physician assistant. Certain healthcare providers such as physical therapists, nurses, physician assistants, and social workers are not considered physicians as defined under FECA.[22] Consequently, their medical findings and/or opinions will not suffice for purposes of establishing entitlement to FECA benefits.

In a series of reports dated from April 6 to 14, 2015, Dr. Carril, a chiropractor, indicated that he treated appellant for right knee pain. The Board notes that section 8101(2) of FECA[23]

[18] *See L.B.*, Docket No. 18-0533 (issued August 27, 2018); *D.K.*, Docket No. 17-1549 (issued July 6, 2018).

[19] *Id*.

[20] *Id*.

[21] *W.M.*, Docket No. 19-1853 (issued May 13, 2020); *L.F.*, Docket No. 19-1905 (issued April 10, 2020).

[22] Section 8101(2) of FECA provides that physician "includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law." 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t). *See also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3a(1) (January 2013); *M.F.*, Docket No. 17-1973 (issued December 31, 2018); *K.W.*, 59 ECAB 271, 279 (2007); *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).

[23] *Supra* note 2.

provides that the term physician, as used therein, includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist and subject to regulation by the Secretary.[24] OWCP's implementing federal regulation at 20 C.F.R. § 10.5(bb) defines subluxation as an incomplete dislocation, off-centering, misalignment, fixation or abnormal spacing of the vertebrae which must be demonstrated on x-ray. As these reports do not diagnose a subluxation as demonstrated by x-ray, they do not constitute probative medical evidence.[25]

As appellant has not submitted rationalized medical evidence establishing a lumbar condition causally related to the accepted December 9, 2014 employment incident, the Board finds that he has not met his burden of proof to establish his claim.

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 has not met his burden of proof to establish a lumbar condition causally related to the accepted December 9, 2014 employment incident.

[24] *Id.*; 20 C.F.R. § 10.311.

[25] *T.H.*, Docket No. 17-0833 (issued September 7, 2017); *Robert H. St. Onge*, 43 ECAB 1169 (1992).

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the August 3, 2020 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 17, 2022
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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

James D. McGinley, Alternate Judge
Employees' Compensation Appeals Board