U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of RONNIE G. MASON and DEPARTMENT OF VETERANS AFFAIRS,
OLIN E. TEAGUE VETERANS CENTER, Temple, TX

Docket No. 98-1682; Submitted on the Record;
Issued April 21, 2000

DECISION and ORDER

Before GEORGE E. RIVERS, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issues are: (1) whether appellant has met his burden of proof in establishing that he was totally disabled commencing October 19, 1997 due to his accepted August 10, 1997 strain of the lumbar region; and (2) whether the Office of Workers' Compensation Programs properly denied appellant's request for a hearing under section 8124 of the Federal Employees' Compensation Act.

On August 10, 1997 appellant, then a 48-year-old housekeeping aid, filed a claim for a traumatic injury alleging that, on that day, he sustained an injury to his lower back while performing his duties. He stated that "bending over cleaning com[m]ode felt sharp pain in my back, left restroom and rested a minute and went to vacuum the directors office, felt sharp [pain] again and could n[o]t straighten up again. Call [ed] my supervisor." On the reverse side of the form the employing establishment stated that appellant stopped work on August 13, 1997 and did not return.

Accompanying the claim were employing establishment health unit records indicating that on August 10, 1997 appellant was seen by Dr. Justin Powell for complaints of back pain, at which time he was diagnosed with low back strain and placed on "light duty tonight"; an August 10, 1997 work restriction, Form OWCP-5, by Dr. Powell restricting appellant's work with "no lifting of any kind rest of tonight" and duration of light duty from August 15, 1997 "[un]til cleared by primary physician"; an August 10, 1997 attending physician's report, Form CA-20, by Dr. Powell diagnosing lumbar strain and "light duty [un]til cleared by primary physician"; a consultation sheet from Dr. Charles D. Ridgley, Board-certified in preventive medicine, providing a provisional diagnosis of acute lumbosacral strain; an August 11, 1997 report of employee emergency treatment by Dr. Ridgley indicating "work limited to desk work through August 18, 1997; an August 11, 1997 employing establishment health unit record by Dr. Powell who diagnosed aggravation of lumbosacral strain and recommended light duty sit down desk work only; an August 11, 1997 Form OWCP-5 by Dr. Ridgley who restricted work to "work limited to light desk work only (answering [tele]phones, *e.g.*) -- no lifting over two

pounds, no stooping, bending or knelling"; an August 14, 1997 Waco allied healthcare referral form by Dr. W.P. Coleman referring appellant to Dr. Marcial G. Lewin, a Board-certified neurological surgeon. Dr. Coleman noted that the "patient went to emergency today hurt back. Dr. Walker called. They did CT [computerized tomography] -- has HNP [herniated nucleus pulposus] at L4-5. Dr. Walker made [an] appointment with [Dr.] Lewin for August 15, 1997"; an undated patient instruction form by Dr. Lewin directing appellant to report on August 21, 1997 for preadmission lab work for surgery that was scheduled for August 26, 1997; and an August 18, 1997 attending physician's report by Dr. Lewin diagnosing spinal stenosis L4-5 with radicular syndrome lower limbs and calcified disk herniation with midline bar. Regarding if he believed that appellant's disability is in any way related to the history of the August 10, 1997 injury as given, *i.e.,* the history given was low back pain for 10 years or so, but became much worse April 1997, Dr. Lewin stated, "All we can do is go by what [appellant] tells me." He indicated surgery was need for bilateral decompression L4-5 that will need to extend laterally. Dr. Lewin also stated that appellant was totally disabled for work from August 15, 1997 to the present.

By letter dated November 5, 1997, the Office accepted appellant's claim for an aggravation of strain of lumbar region.

On November 5, 1997 the record was supplemented with an October 20, 1997 claim for compensation on account of traumatic injury or occupational disease, Form CA-7. On the reverse side of the form, the employing establishment stated that appellant received continuation of pay from August 13 to September 26, 1997, was on annual/sick leave from September 27 to October 5, 1997, was on donated leave until October 14, 1997 and leave without pay began October 19, 1997.

By letter dated November 4, 1997, Dr. Lewin, requested authorization for surgery which involved L4-5 decompressive laminectomy, posterior lumbar interbody fusion, posterior instrumentation with ray cages and harvesting of bone for fusion. In support, he forwarded a report of an August 14, 1997 CT scan of the lumbar spine by Dr. C.E. Huffman, a Board-certified radiologist. Dr. Huffman's interpretation of the CT scan was:

> "Spinal stenosis at L4-5 from hypertrophy of the facets bilaterally and from either a calcified herniated fragment or osteophytic projection extending posteriorly. I estimate the degree of canal stenosis to be approximately 50 [to] 60 [percent] at this level. Posterior bulging or slight protrusion of the disc at L5-S1 towards the left side. There is hypertrophy of the facets at this level as well and together these cause slight encroachment on the neural foramen on the left side at L5-S1. Mild broad base bulging of the disc at L3-4 but no focal disc herniation identified."

Also provided were Dr. Lewin's Office notes for August 25 and October 29, 1997. On August 25, 1997 he discussed the need for surgery with appellant and the need to get his claim under workers' compensation straightened out first. On October 29, 1997 Dr. Lewin noted that appellant needed surgery, but deferred that decision to appellant's primary care physician, Dr. Coleman. Dr. Lewin again mentioned the pending workers' compensation claim.

Dr. Lewin also submitted an August 15, 1997 report in which he noted a history of low back pain for 10 years or so. He stated that "[a]ll of this became worse in April 1997." Dr. Lewin stated that a CT scan of the lumbar spine on August 14, 1997 showed a calcified disc at the L4-5 level with significant spinal stenosis, as well as foraminal stenosis. He stated at L5-S1 there are some degenerative changes, but no significant disc herniation. Dr. Lewin diagnosed spinal stenosis L4-5 with radicular syndrome lower extremities and calcified disc herniation with midline bar. He also stated:

> "I think [appellant] needs surgery. He has significant compression of the spinal canal at the L4-5 level secondary to a large dis[c] herniation that has produced a calcified osteophyte and big midline bar across the inter-space. I think [appellant] needs bilateral decompression at L4-5 that will need to extend laterally. This will produce instability and a fusion should be placed. I think Ray cages will be ideal for this situation. This will maintain the height of the inter-space as well as provide good stability and good solid inter-body fusion."

By letter dated November 5, 1997, the Office notified Dr. Lewin that he must provide a report which identified the surgical procedure, specific condition to be treated by surgery and the benefit from having the surgery.

On November 5, 1997 the record was supplemented with appellant's leave record from August 3 through November 9, 1997 and a September 26, 1997 attending physician's report, Form CA-20, by Dr. Lewin diagnosing spinal stenosis L4-5, radicular syndrome, lower limbs and calcified disk HNP midline bar. On the question of whether he believed that appellant's condition was caused or aggravated by his employment activity he stated, "We go by what [appellant] says." Dr. Lewin indicated that appellant was totally disabled from August 15, 1997 to current.

In a response from Dr. Lewin's office to the Office's November 5, 1997 request for information concerning recommended surgery, it was noted that on November 4, 1997 most of the information requested had been sent. He stated that his diagnosis included displacement of lumbar disc, lumbar stenosis and radicular syndrome. Dr. Lewin stated that the obvious benefits from the surgery would include reduction or elimination of back pain and/or radicular pain in order to return [appellant] to his employment and that the estimated time off of work postop is normally six weeks.

By letter dated November 10, 1997, the Office advised appellant that his claim for compensation, Form CA-7, had been received and that additional evidence was needed. Specifically, medical evidence establishing disability for work during the period commencing October 19, 1997.

By decision dated November 24, 1997, the Office denied appellant's claim for total disability for work commencing October 19, 1997, finding that the medical evidence of record failed to establish that appellant was disabled for work due to his accepted August 10, 1997 aggravation of strain of the lumbar spine.

On November 24, 1997 the record was supplemented with appellant's employing establishment medical file which included a June 19, 1997 magnetic resonance imaging (MRI) scan of the lumbar spine by Dr. Harry H. Ko, a Board-certified radiologist, who interpreted the results as showing minimal spinal stenosis of the central canal and both neural foramina at L4-5 by disc bulging and osteophytosis and hypertrophy of ligamentum flavum; a May 16, 1997 bone imaging whole body by Dr. John G. Hutka, a Board-certified radiologist, who interpreted the results as showing inflammatory/degenerative changes right tibial-fibular joint; a May 9, 1997 report of physical examination by Dr. Stephen Howlette, a Board-certified neurologist, who diagnosed lumbar disk, chronic partly calcified at L4-5 on the left side with vague radicular complaints and probably degenerative disease in his facet joints at multiple levels; an April 4, 1997 lumbar CT scan by Dr. Jerry R. Wright, a Board-certified radiologist, who interpreted the results as showing "L3-4 normal, L4-5 protruding disc posterior and to the left side. Disc is partially calcified. Protruding disc is causing some flattening of the dural sac. There is mild narrowing of the posterior joints, L5-S1. There is some mild generalized bulging of the disc. No focal herniations are seen. There is mild narrowing of the posterior joints"; a February 11, 1997 radiographic report by Dr. Edward L. Smith, Board-certified in nuclear medicine and radiology, who interpreted the results as showing six lumbarized segments with narrowing of the disc space below L5, anterior spurring margins of the bodies of L4, 5 and 6, lumbar spine otherwise unremarkable; and a November 19, 1991 radiographic report by Dr. John T. Davis, a Board-certified radiologist, of the lumbosacral spine interpreted as revealing slight degenerative spondylosis in addition to a segmentation anomaly with six lumbar vertebrae.

By letter postmarked January 12, 1998, appellant requested an oral hearing before an Office hearing representative.

By decision dated March 9, 1998, the Office's Branch of Hearings and Review denied appellant's request on the grounds that it was not filed within 30 days of the Office's last merit decision issued on November 24, 1997. The Office stated that it had considered the matter in relation to the issue involved and further denied appellant's hearing request on the basis that the case could be resolved by submitting additional evidence on reconsideration to establish that he was disabled for work for the period October 19, 1997 to the present.

The Board finds that, appellant has failed to meet his burden of proof in establishing that he was totally disabled for work commencing October 19, 1997.

In this case, the record supports that appellant suffered an aggravation of a strain of the lumbar region, which the Office accepted. On November 5, 1997 appellant filed a claim for compensation on account of traumatic injury (Form CA-7) alleging that he was totally disabled for work commencing October 19, 1997.[1]

The medical evidence in support of his claim for total disability from October 19, 1997 to the present consisted of an October 29, 1997 office note by Dr. Lewin. He stated that appellant's condition remained about the same, if not getting worse. Dr. Lewin stated: "It is my opinion that [appellant] cannot work as he is at this moment. He needs the surgery; however, his

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[1] *See Donald Leroy Ballard,* 43 ECAB 876 (1992).

primary/treating physician is Dr. Bill Coleman and I will defer that opinion to him." Dr. Lewin diagnosed appellant with spinal stenosis L4-5 with radicular syndrome lower extremities and calcified disc herniation with midline bar. His October 24, 1997 office note failed to address a causal relationship between appellant's disability for work commencing October 19, 1997 and his accepted August 10, 1997 aggravation of lumbar strain. On the issue of causal relationship Dr. Lewin stated, "We go by what [appellant] says." Therefore, Dr. Lewin's October 29, 1997 office note is insufficient to establish appellant's claim.

Also submitted was a November 13, 1997 report by Dr. Lewin's office restating information previously provided by him in an August 15, 1997 report concerning authorization for surgery. The report failed to address a causal relationship between appellant's disability for work commencing October 19, 1997 due to his accepted August 10, 1997 aggravation of lumbar strain. The report also failed to address a causal relationship between appellant's diagnosed condition/need for surgery and the August 10, 1997 employment-related incident. The report is insufficient to establish appellant's claim.

Also submitted was an attending physician's report, a Form CA-20 dated September 26, 1997 by Dr. Lewin. He diagnosed spinal stenosis L4-5, radicular syndrome lower limbs and calcified disc HNP with midline bar. Dr. Lewin stated that appellant was totally disabled from August 15, 1997 to current. On the question of causal relationship he stated: "We go by what [appellant] says." He failed to provide a rationalized medical opinion causally relating appellant's disability for work from October 19, 1997 to the present to his accepted August 10, 1997 aggravation of lumbar strain. Dr. Lewin did not causally relate appellant's diagnosed condition/need for surgery to the employment-related August 10, 1997 incident or his disability for work from October 19, 1997 to present. The September 26, 1997 attending physician's report is insufficient to establish appellant's disability for work claim.

The medical evidence submitted in support of appellant's employment-related injury on August 10, 1997, revealed that appellant has had problems with his back for about 10 years. He was diagnosed with spinal stenosis L4-5 with radicular syndrome lower extremities and calcified disc herniation with midline bar. However, appellant failed to provide a physician's opinion supported by rationale causally relating his diagnosed condition and his need for surgery to correct the condition to the accepted August 10, 1997 employment-related incident. The Office only accepted the condition of aggravation of strain of the lumbar region. By letter dated November 10, 1997, appellant was advised that in order to establish his claim for total disability commencing October 19, 1997 he would need to submit medical evidence establishing that his disability for work was due to his accepted aggravation of the lumbar strain. This evidence was not provided. Therefore, the Board finds that the evidence of record is insufficient to meet appellant's burden of proof.

The Board further finds that the Office properly denied appellant's request for a hearing under section 8124 of the Act.

Section 8124(b)(1) of the Act, concerning a claimant's entitlement to a hearing before an Office hearing representative, provides in pertinent part: "Before review under section 8128(a) of this title, a claimant for compensation not satisfied with a decision of the Secretary … is entitled, on request made within 30 days after the date of the issuance of the decision, to a

hearing on his claim before a representative of the Secretary."[2] As section 8124(b)(1) is unequivocal in setting forth the time limitation for requesting a hearing, a claimant is not entitled to a hearing as a matter of right unless the request is made within the requisite 30 days.[3]

The Board has held that the Office, in its broad discretionary authority in the administration of the Act, has the power to hold hearings in certain circumstances where no legal provision was made for such hearings and that the Office must exercise this discretionary authority in deciding whether to grant a hearing.[4] Specifically, the Board has held that the Office has the discretion to grant or deny a hearing request on a claim involving an injury sustained prior to the enactment of the 1966 amendments to the Act which provided the right to a hearing,[5] when the request is made after the 30-day period for requesting a hearing[6] and when the request is for a second hearing on the same issue.[7]

In the present case, appellant's hearing request was made more than 30 days after the date of issuance of the Office's prior decision dated November 24, 1997 and, thus, appellant was not entitled to a hearing as a matter of right. He requested a hearing in a letter postmarked January 12, 1998. Therefore, the Office was correct in finding in its March 9, 1998 decision that appellant was not entitled to a hearing as a matter of right because his hearing request was not made within 30 days of the Office's November 24, 1997 decision.

While the Office also has the discretionary power to grant a hearing when a claimant is not entitled to a hearing as a matter of right, the Office, in its March 9, 1998 decision, properly exercised its discretion by stating that it had considered the matter in relation to the issue involved and had denied appellant's hearing request on the basis that the case could be resolved by submitting additional evidence to establish that his disability for work for the period October 19, 1997 to present was causally related to his accepted August 10, 1997 lumbar region sprain. The Board has held that as the only limitation on the Office's authority is reasonableness, 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 deduction from established facts.[8] In the present case, the evidence of record does not indicate that the Office committed any act in connection with its denial of appellant's hearing request which could be found to be an abuse of discretion. For these, reasons, the Office properly denied appellant's request for a hearing under section 8124 of the Act.

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[2] 5 U.S.C. § 8124(b)(1).

[3] *Ella M. Garner*, 36 ECAB 238, 241-42 (1984).

[4] *Henry Moreno*, 39 ECAB 475, 482 (1988).

[5] *Rudolph Bermann*, 26 ECAB 354, 360 (1975).

[6] *Herbert C. Holley*, 33 ECAB 140, 142 (1981).

[7] *Johnny S. Henderson*, 34 ECAB 216, 219 (1982).

[8] *Daniel J. Perea*, 42 ECAB 214, 221 (1990).

The decisions of the Office of Workers' Compensation Programs dated March 9, 1998 and November 24, 1997 are affirmed.[9]

Dated, Washington, D.C.
April 21, 2000

George E. Rivers
Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member

[9] The Board notes that appellant submitted new evidence with his appeal. However, the Board may not consider such evidence for the first time on appeal. The Board's jurisdiction is limited to reviewing the evidence that was before the Office at the time of its final decision. 20 C.F.R. § 501.2(a). Appellant may resubmit this evidence to the Office, together with a formal request for reconsideration pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. § 10.606(b).