U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of MARTHA B. HOLCOMB and U.S. POSTAL SERVICE,
POST OFFICE, Atlanta, GA

Docket No. 01-664; Submitted on the Record;
Issued February 21, 2002

DECISION and ORDER

Before WILLIE T.C. THOMAS, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issue is whether appellant has established that she sustained an injury on April 20, 1999 in the performance of duty, causally related to factors of her federal employment.

On January 7, 2000 appellant, then a 54-year-old operations quality improvement specialist, filed a claim alleging that on April 20, 1999 she slipped on liquid on a floor and fell backward on her right leg while catching her right arm. Appellant alleged that she sustained a C5-6 disc bulge, a pinched nerve, pain in her right shoulder, tendinitis in her right elbow and arthritis in her right knee. Appellant stopped work on April 20, 1999 and did not return.

On January 19 and 21, 2000 the employing establishment controverted appellant's claim noting that appellant did not report the alleged incident for almost nine months after it happened, that the medical evidence submitted in support of her claim identified an anxiety/stress condition with headaches and diarrhea as her disabling condition and that appellant identified "sickness" as her reason for taking sick leave instead of an on-the-job injury as the reason for her incapacitation.

In support of her claim, appellant submitted reports from her Board-certified internists, Dr. Jamie D. Pappas and Dr. Samuel W. Eden. Reports from Dr. Pappas dated May 21, June 22, July 20 and August 17, 1999, noted that appellant had been under his care for several years, that she had been in fairly good health until approximately September 1998, Dr. Pappas reported that at that time she began to have problems manifesting as illness causing deterioration in her overall health such that she was unable to perform her usual activities. In Dr. Pappas' July 20 and August 17, 1999 report, he identified appellant's symptoms as anxiety/stress resulting in headaches and diarrhea.

Reports dated September 16, November 29 and December 28, 1999 from Dr. Eden stated that appellant was under his care, that her symptoms were anxiety/stress, which resulted in headaches and diarrhea and that he felt that she was unlikely to be able to resume her usual activities without reactivating severe symptoms.

By report dated January 4, 2000, Dr. R. Bruce Prince, a Board-certified psychiatrist, noted that appellant was under his care for depression and anxiety accompanied by multiple somatic difficulties including headaches, irritable bowel syndrome and general muscle aches and spasms. Dr. Prince opined: "Her symptoms of depression and anxiety appear to me to stem from situations which occurred in her work setting…. [I]n understanding her difficulties it is quite clear that there is a traumatic element to her problems which originated in her work setting." He opined that the chances of appellant returning to her work setting were slight.

By letter dated January 28, 2000, the Office of Workers' Compensation Programs advised appellant that the information submitted was insufficient to establish her claim and it requested further medical reports with results of testing and an opinion on causal relation.

By letter dated February 24, 2000, appellant submitted a February 1, 2000 report from Dr. Eden who noted that appellant was suffering from a C5-6 disc bulge and pinched nerve. He noted that she continued to experience anxiety, stress, headaches, stomach pains and diarrhea and opined that due to these infirmities she could not resume her usual activities.

Additionally submitted were two magnetic resonance imaging (MRI) scan reports. The report dated December 20, 1999, was an MRI scan of the right shoulder, which was reported as demonstrating mild supraspinatus tendinitis. A rotator cuff tear was not identified. The December 28, 1999 MRI scan of the cervical spine was reported, as follows:

> "Broad posterior osteophyte at the C5-6 level which is associated with a broad disc bulge. The osteophyte and disc bulge is flattening the ventral surface of the thecal sac and is producing contact with the mid and right side of the cord. The osteophyte extends into the right side of the neural foramen and is producing right sided intraforaminal encroachment. Degenerative disc dissociation at the C5-6 level."

On February 25, 2000 the Office received a February 17, 2000 report from Dr. Eden, which noted that appellant told him that she fell at work injuring her neck, shoulder and knee. Dr. Eden noted that since that time appellant had developed progressive headaches and bilateral arm pain and abdominal pain and diarrhea probably related to the nonsteroidal anti-inflammatory drugs to treat the headaches. He reported MRI scan results and opined that these produced "high grade neuropathic changes in the trigeminal distribution V2 and V3 with involvement bilaterally of the lesser occipital nerves of high grade indicating an injury to C2 from the fall. In addition, there is an injury of high grade to the right C3 nerve root and a severe injury to the C4 nerve roots as well as the C5. C6 shows severe bilateral radicular changes. All of the preceding abnormalities are causing her current complaints." Dr. Eden noted that appellant's physical findings as including severe muscle spasms and cephalgia secondary to neck injury and he opined: "It is my prudent medical opinion that the impact trauma that [appellant] suffered at work created a serious injury to her neck, which is permanent and insoluable."

By decision dated March 6, 2000, the Office rejected appellant's traumatic injury claim finding that fact of injury had not been established. The Office found that it was nine months before appellant reported the incident, that none of the contemporaneous medical reports

mentioned any April 20, 1999 incident at work and that the most recent report from Dr. Eden was unrationalized and did not demonstrate that he had an accurate history of injury.

By letter dated March 14, 2000, appellant requested an oral hearing before an Office hearing representative. The hearing was held on June 27, 2000 at which appellant testified that she did not report the injury because she was "okay at the time." In support appellant submitted a February 24, 2000 report from Dr. Eden, which reiterated his February 17, 2000 report.

By letter dated July 26, 2000, Dr. Eden noted: "A person may have osteo-type formation and disc dissociation and no symptoms may be noted. Symptoms may become activated secondary to a traumatic event. The mechanism for this type of occurrence is multifactorial. The pain and disability nevertheless are real."

Following the hearing appellant submitted an August 1, 2000 report from Dr. Pappas, which noted that appellant did indeed see him on April 21, 1999 complaining of "right knee pain suffered from an accident at work." Dr. Pappas indicated that x-rays were negative and that he felt appellant's injuries were minimal and would improve over the ensuing months. Dr. Pappas noted that unfortunately appellant's injuries continued to be painful and problematic and that further tests revealed the "true injury."

Also submitted were treatment notes about appellant's allergic problems and rhinitis, headaches, depression and anxiety, her right knee and her irritable bowel syndrome. Additionally, duplicate copies of the MRI scan reports were resubmitted.

By decision dated October 18, 2000, the hearing representative affirmed the March 6, 2000 decision. The hearing representative found that none of the medical reports provided a rationalized opinion on causal relation of the neck injury, initially commenting only of her depression/anxiety and gastrointestinal problems and in the spring of 2000 referring generally to appellant's other "injury at work." It was noted that no specific diagnosis was given, referring only to the "true injury," and that no complaints of pain were reported until the spring of 2000.

The Board finds that appellant has failed to establish that she sustained an injury on April 20, 1999.

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it must first be determined whether a "fact of injury" has been established. First, the employee must submit sufficient evidence to establish that he or she actually experienced the employment incident at the time, place and in the manner alleged.[1] Second, the

[1] *John J. Carlone*, 41 ECAB 354 (1989). To establish that an injury occurred as alleged, the injury need not be confirmed by eyewitnesses, but the employee's statements must be consistent with the surrounding facts and circumstances and his subsequent course of action. In determining whether a *prima facie* case has been established, such circumstances as late notification of injury, lack of confirmation of injury and failure to obtain medical treatment may, if otherwise unexplained, cast sufficient doubt on a claimant's statements. The employee has not met this burden when there are such inconsistencies in the evidence as to cast serious doubt on the validity of the claim. *Carmen Dickerson*, 36 ECAB 409 (1985); *Joseph A. Fournier*, 35 ECAB 1175 (1984); *see also George W. Glavis*, 5 ECAB 363 (1953).

employee must submit sufficient evidence, generally only in the form of medical evidence, to establish that the employment incident caused a personal injury.[2]

In this case, the Office accepted that appellant experienced the April 20, 1999 employment incident at the time, place and in the manner alleged. However, appellant has submitted insufficient medical evidence to establish that the employment incident caused a personal injury.

The most contemporaneous reports from appellant's internist, Dr. Pappas noted that appellant began to have problems around September 1998 described as "illness causing deterioration in her overall health." These reports do not mention the April 20, 1999 incident or any specific injury that may have resulted from it. Consequently, these reports do not support appellant's traumatic injury claim. His August 1, 2000 report did note that he saw appellant on April 21, 1999 for complaint of right knee pain suffered from an accident at work; however, neither the date nor the specifics of any such accident were identified, nor did Dr. Pappas mention any complaints of neck, right shoulder or right upper extremity pain at the time of examination. Rather, he noted that appellant's injuries were minimal and would improve over the ensuing months. Dr. Pappas reference to appellant's subsequently manifested "true injury" is vague and unsupported by any rationale. Consequently, this report also is of insufficient probative value to establish that appellant sustained an injury on April 20, 1999 under the Federal Employees' Compensation Act.

The reports from Dr. Eden identified appellant's symptoms, for which he treated her during the period September 16 through December 28, 1999 as anxiety/stress, which resulted in headaches and diarrhea. No mention of any neck, right shoulder, right arm or right knee problems was made and no date of injury was identified. Consequently, none of these reports support appellant's April 20, 1999 traumatic injury claim. By later report dated February 1, 2000, Dr. Eden first noted that appellant was "suffering from a C5-6 disc bulge, pinched nerve," but he failed to discuss when and how these problems arose or how they were related to appellant's employment. Dr. Eden discussed appellant's continued problems of anxiety/stress, headaches and stomach problems. No relationship with any specific factor of her employment was implicated. Consequently, this report does not support appellant's April 20, 1999 traumatic injury claim.

The MRI scan results from December 28, 1999, upon which Dr. Eden based his diagnostic opinion, contained no opinion on causal relation and, therefore, have little probative value in supporting appellant's claim. They merely show degenerative changes, osteophytes and disc dissociation to appellant's cervical spine.

Dr. Eden, in his later reports beginning in February 2000, indicated that appellant had now told him that she had fallen at work 10 months earlier, injuring her neck, shoulder and knee. This history reveals that appellant's traumatic incident occurred 10 months earlier. Dr. Eden did not fully address this history of injury, but merely noted that since that time appellant had developed the symptoms of which she complained. Dr. Eden reviewed the MRI scan results and discussed the cervical clinical pathologic changes demonstrated from them, but failed to

[2] *Id.* For a definition of the term "injury," *see* 20 C.F.R. § 10.5(a)(14).

provided a rationalized medical opinion relating these MRI scan changes to the April 20, 1999 incident merely noting that they indicated a C2 injury "from the fall." Dr. Eden did not explain how a degenerative osteophyte at the C5-6 level associated with a broad disc bulge flattening the ventral surface of the thecal sac contacting the right side of the cord and causing right intraforaminal encroachment, indicated injury to C2, or high grade neuropathic changes in the trigeminal distribution. He further stated that injury of high grade was also demonstrated at the C3 nerve root and the C4 nerve root, as well as C5-6 roots with bilateral radicular changes. However, Dr. Eden failed to discuss how a disc bulge and disc dissociation visualized by MRI scan at C5-6 caused pathology at C3 or C4, or how degenerative changes such as osteophyte formation or disc dissociation were caused traumatically by a fall eight months earlier. His opinion on causal relationship is conclusory in nature and omitted any explanation as to how such extensive degenerative changes were due to a trauma eight months earlier. The Board has frequently explained that medical conclusions unsupported by rationale are of diminished probative value.[3] As Dr. Eden's reports are not fully rationalized, they are of diminished probative value.

Dr. Eden's most recent report discussed the hypothetical patient with osteo-type formation and disc dissociation who is asymptomatic, may have activated symptoms secondary to trauma. As this is a hypothetical model, it is not clearly specific to this case as it is of general application and is not determinative to the facts of this specific case and, therefore, has little evidentiary value.[4] Moreover, Dr. Eden failed to identify the specific traumatic event implicated or explain why, if that event activated appellant's symptomatology, it was not complained of by appellant nor was it noted or diagnosed by him during the intervening nine months. Due to these deficiencies, the reports of Dr. Eden are of diminished probative value.

The January 2000 report from Dr. Prince, relatively contemporaneous with the February 1, 2000 report from Dr. Eden, did not mention the April 20, 1999 accident nor did Dr. Prince diagnose any neck problems, right shoulder or upper extremity problems, or right knee arthritis. He opined that appellant had depression and anxiety problems which were manifested by headaches, irritable bowel syndrome and general muscle aches and spasms. Dr. Prince did not identify the 1999 incident as a causative factor and failed to diagnose her specifically claimed injuries/conditions. His reference to problems originating from a traumatic element in her work setting is vogue. His reports are of diminished probative value.

[3] *Vicky L. Hannis*, 48 ECAB 538 (1997); *Jacquelyn L. Oliver*, 48 ECAB 232 (1996).

[4] *See Ronald M. Cokes*, 46 ECAB 967 (1995); *Ruby I. Fish*, 46 ECAB 276 (1994); *Kathleen D. Walker*, 42 ECAB 603 (1991).

The October 18 and March 6, 2000 decisions of the Office of Workers' Compensation Programs are hereby affirmed.

Dated, Washington, DC
February 21, 2002

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member