U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of NEMAT M. AMER and DEPARTMENT OF THE TREASURY, BUREAU OF PRINTING & ENGRAVING, Washington, DC

Docket No. 03-338; Submitted on the Record;
Issued April 7, 2003

DECISION and ORDER

Before ALEC J. KOROMILAS, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issue is whether appellant has established that she sustained a back injury in the performance of duty.

On November 20, 2000 appellant, then a 61-year-old management analyst, filed a traumatic injury claim alleging that on December 2, 1998 she hurt her back and sustained an emotional condition due to factors of her federal employment. In an accompanying statement dated November 20, 2000, she indicated that she experienced severe pain in her lower back while moving her belongings from the fifth floor to the third floor. Appellant stated that she dragged her feet to the health section on the seventh floor where she collapsed and was taken to the emergency room of a local hospital for her back pain, emotional stress and severe depression. She further stated that she was treated in the mental section of the hospital for three days.[1]

By letters dated August 2, 2001, the Office of Workers' Compensation Programs advised appellant to submit factual and medical evidence supportive of her claim.

In a response letter dated August 14, 2001, appellant indicated that the Office had only previously addressed her entitlement to compensation for her emotional condition and not her back condition. She stated that her claim was specifically for her back condition. Appellant stated that she hurt her back on December 2, 1998 while moving boxes and office equipment as ordered by her superiors. She stated that she aggravated a previous back injury she sustained on May 30, 1995. Appellant further stated that her December 2, 1998 injury triggered a severe emotional breakdown that required her to be hospitalized for three days. She also stated that her physical injury was never properly considered. Appellant provided names and addresses of those that witnessed or had immediate knowledge of her injury, including a nurse in the employing establishment's health unit.

[1] Prior to the instant claim, appellant filed a traumatic injury claim for an injury sustained on March 10, 1995. The Office accepted appellant's claim for a neck sprain/strain. Subsequently, appellant filed a traumatic injury claim for an injury sustained on May 30, 1995 that was accepted by the Office for cervical sprain and contusion. On April 24, 2000 the Office denied appellant's occupational disease claim alleging that she suffered severe disc pain in her lower back on May 30, 1995.

In an August 29, 2001 letter, appellant provided a history of her previous back injuries and asserted that the record should contain documents indicating that she was taken to the employing establishment's health unit in a wheelchair on December 2, 1998.

Appellant submitted medical evidence regarding her back condition in support of her claim. A September 29, 1999 magnetic resonance imaging (MRI) report from Dr. Sameer Samtani, a radiologist, revealed a large central herniated nucleus pulposus at L4-5 resulting in severe spinal stenosis and bilateral neural foraminal stensosis greater in the right than in the left with impingement of the exiting L4 nerve roots. Dr. Samtani further diagnosed moderate spinal stenosis at L5-S1 secondary to a broad central disc and bilateral neural foraminal stenosis, left greater than the right with impingement of the exiting L5 nerve roots. Lastly, Dr. Samtani diagnosed a disc bulge at L3-4.

An August 27, 1997 MRI report of Dr. Mark Monteferrante, a Board-certified radiologist, revealed multilevel degenerative disc bulging, spondylosis and degenerative hypertrophy of the facet joint and spinal ligaments. Dr. Monteferrante stated that the degenerative changes were most pronounced at L3-4 and L4-5 where there was mild central canal stenosis with focal stenosis of the right lateral recess at L4 and the left lateral recess at L4-5. He further stated that bilateral encroachment of the neural foramina was also present at both of these levels. Dr. Monteferrante concluded that no other area of significant spinal stenosis was present.

In an October 14, 1997 report, Dr. James Burgess, a Board-certified neurosurgeon, provided a description of appellant's May 1995 back injury and medical treatment. He further provided a history of appellant's medical background and his findings on neurological examination. Dr. Burgess stated that appellant complained of recurrent pain in her left hip and leg that was likely due to a herniated disc at the L4-5 level. He also stated that the MRI scan of the L3-4 level and herniated disc to the right of that level did not appear to currently be the symptomatic site. Dr. Burgess recommended that appellant undergo surgery to relieve her symptoms and noted her reluctance to do so.

An October 15, 1996 MRI report of Dr. Abbott Huang, a radiologist, indicated evidence of disc degeneration and a large diffuse disc bulge with mild narrowing of the bilateral neural foramen at the L3-4 level. Dr. Huang's report further indicated moderate decrease height of the intervertebral disc with disc degeneration at the L4-5 level and a large diffuse disc bulge with moderate narrowing of the bilateral neural foramen.

A September 27, 1995 x-ray report of Dr. John A. Long, Jr., a Board-certified radiologist, revealed a slightly bulging disc at L5-S1 and a more severely bulging disc at L4-5 with narrowing of the spinal canal and some stenosis of the spinal canal. Another significant bulging disc was noted at L3-4 and unremarkable conus medullaris.

In a January 22, 1999 report, Dr. Neng-yu Fang, a licensed acupuncturist, stated that appellant was treated with acupuncture for her severe protrusive disc at L3-4 and L5-S1. Dr. Fang noted appellant's symptoms, which included severe pain of the lower back and sciatic nerves, limited bending and rotation of her loin, weak legs and inability to control urination. He stated that the acupuncture treatment gave appellant some relief, but it could not alleviate her severe pathologic structural lesion. Dr. Fang concluded that appellant was still undergoing acupuncture treatment.

In his August 7, 2001 report, Dr. Fang provided a description of appellant's May 30, 1995 injury and reiterated his findings set forth in his January 22, 1999 report. He stated that he treated appellant at home approximately twice a month and on December 12, 1998 she told him that on December 2, 1998 she was moving heavy boxes of files and binders, and office equipment at work from one floor to another and suffered unbearable pain in her lower back and left leg all the way to her foot. Appellant stated that she was admitted to the health section where she was given a painkiller and was taken to the hospital. Dr. Fang opined that based on appellant's medical records and MRI reports, her December 1998 sprained lower back in carrying heavy materials at her office, apparently was directly related to her longtime injury of May 1995, which caused deterioration of the bulging disc and pinched nerve. Dr. Fang stated that appellant's herniated disc entrapped the roots of nerves and caused typical sciatic syndrome.

The January 14, 1999 report of Dr. Hampton J. Jackson, Jr., a Board-certified orthopedic surgeon, provided a history of appellant's May 30, 1995 injury, a review of appellant's medical records and his findings on physical examination. He diagnosed a ruptured lumbar disc at L3-4 subsequent to the May 30, 1995 injury, evidence of disc injury to L5-S1 as a result of the May 30, 1995 injury and chronic lumbar strain with evidence of injury to ligamentous structures at L3-4, L4-5 and L5-S1 superimposed upon a preexisting asymptomatic decreased spinal canal (x-ray spinal stenosis). Dr. Jackson stated that appellant's condition had not improved since her injury, approximately three and one-half years ago. He recommended surgery to improve appellant's back condition, however, noting that there was no guarantee of future pain.

Dr. Jackson's September 23, 1999 report revealed evidence of significant sciatica. He stated that appellant was a candidate for surgery due to the injuries she sustained on May 30, 1995 although there was no guarantee of good results. Dr. Jackson opined that appellant's fall from a chair on May 30, 1995 was the cause of her work-related injury. He noted the history provided by appellant that on December 1, 1998 she was ordered to clean out her workspace and she reinjured her back on that date while lifting and moving items. Dr. Jackson recommended that appellant continue with acupuncture and chiropractic treatments. He concluded that appellant's condition was permanent and thus, she was not fit for any gainful employment.

In his August 23, 2001 report, Dr. Jackson stated that appellant hurt her back at work on May 30, 1995 and opined that her current back condition was directly related to that injury. He further opined that appellant's condition deteriorated after May 30, 1995 and was aggravated by an injury on the job on December 2, 1998. Dr. Jackson stated that appellant was not fit for any gainful employment. He further stated that in addition to her disc injuries at L4-5 and L5-S1, appellant had a severe emotional consequence of her first and last injury at work, noting the December 2, 1998 incident.

In an August 28, 2001 report, Dr. Ulrich Prinz, a Board-certified internist, noted appellant's May 1995 back injury and stated that there was no prior history of back pain. Dr. Prinz stated that there appeared to be a clear causal link between appellant's subsequent back symptoms and her fall at work. He noted that appellant's back pain had persisted since her accident. Dr. Prinz stated that on December 2, 1998 appellant was moving office equipment when she aggravated her previous back injury and that Dr. Arcadius H. Hakim, a family practitioner and appellant's treating physician, evaluated her at that time. Dr. Hakim provided a history of his treatment of appellant's emotional and back conditions beginning on February 7, 1997. He concluded that appellant had chronic low back pain with associated changes on magnetic resonance imaging and detectable neurological deficits on neurological

examination, which should be taken into account when determining her eligibility for disability retirement.

Dr. Hakim's August 20, 2001 report indicated that appellant was treated for her May 30, 1995 back injury from 1995 through 1998. He stated that he examined appellant on December 5, 1998 and that she was suffering from additional trauma to her existing injured lower back due to twisting her body while lifting and moving heavy boxes and office equipment at work. Dr. Hakim also stated that appellant suffered a major depressive episode. He noted that appellant was taken to a hospital on December 2, 1998 and received psychiatric treatment as an outpatient for the next two weeks. Dr. Hakim further noted that appellant was under regular psychiatric treatment for her depression and she continued to have constant severe pain in her lower back due to her May 30, 1995 injury. He stated that appellant was being treated with medication, physical therapy and acupuncture. Dr. Hakim concluded that appellant had not been able to return to work since the December 2, 1998 incident and she was on permanent disability.

An October 4, 1999 report of Dr. Don Soeken, Ph.D., a psychotherapist, indicated appellant's sincerity in being an ethical federal government employee. Regarding the December 2, 1998 incident, Dr. Soeken stated that appellant was moving her office supplies and computer when she injured her back. He stated that appellant sought treatment from the nursing station and was taken to the hospital for medical treatment. Dr. Soeken opined that there was sufficient evidence to establish that appellant sustained physical and emotional injury due to the moving of her office supplies. He stated that the lack of medical treatment for appellant's back condition caused anger and anxiety, which aggravated her back and emotional conditions.

In controverting appellant's claim, the employing establishment submitted several statements from its employees. Regina Smith-Brown provided a statement indicating that according to appellant she suffered from job-related stress due to conflicts with her supervisor. Mrs. Smith-Brown indicated that, in order to reduce appellant's stress, she was reassigned to another office.

In a memorandum to the file dated December 2, 1998, Ms. Smith-Brown indicated that appellant became very emotional while being welcomed to her new assignment. She further indicated that appellant stated that she wanted to go to the health unit and that her request was approved.

A note to the file of the same date revealed that appellant expressed anger and dissatisfaction about how she was treated in her previous office. The note also revealed that appellant was granted permission to go to the health unit because she experienced difficulty in breathing. The employing establishment was advised by a telephone call 15 to 20 minutes later that appellant had been taken to the nearest hospital by ambulance.

In a February 11, 1999 statement, Anthony X. Hoyer, clarified a statement made by Dr. Prinz that appellant flipped bricks (bundles of money weighing approximately 8 to 10 pounds) at her previous employment. Mr. Hoyer stated that appellant only performed this duty on April 6, 1998 for less than one hour and that she never performed this task again. He further stated that appellant's job duties were of a sedentary nature. Regarding the December 2, 1998 incident, Mr. Hoyer stated that he received a telephone call from a hospital employee requesting him to confirm appellant's statement that her medical condition was work related. He told the

employee that he could not confirm her statement because he was not a doctor and he did not see appellant after approximately 12:00 p.m. on December 2, 1998.

By decision dated September 28, 2001, the Office found the evidence of record insufficient to establish that appellant sustained an injury in the performance of duty. The Office found that the medical evidence of record failed to describe the December 2, 1998 incident and to address whether appellant's back and emotional conditions were caused or aggravated by factors of her employment on December 2, 1998.

In an October 22, 2001 letter, appellant, through her attorney, requested a review of the written record.

By decision dated May 7, 2002, the hearing represented vacated the Office's decision and remanded the case for further development of the evidence. On remand, the hearing representative ordered the Office to obtain medical records from the employing establishment to determine whether appellant was treated for a back condition in its health unit on December 2, 1998. In addition, the hearing representative ordered the Office to obtain the December 5, 1998 treatment records of Dr. Hakim to determine whether appellant was treated for a back condition at that time.

On remand, the Office obtained appellant's medical records from the employing establishment, including treatment notes dated December 2, 1998 indicating that appellant was treated in its health unit for complaints of work-related stress and that she was transported by ambulance to a local hospital.[2]

By decision dated September 4, 2002, the Office found the evidence of record insufficient to establish that appellant sustained an injury in the performance of duty.

The Board finds that appellant has failed to establish that she sustained a back injury in the performance of duty.

To determine whether an 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.[3] To establish that an injury occurred as alleged, eyewitnesses need not confirm the injury, but the employee's statements must be consistent with the surrounding facts and circumstances and her 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.[4]

[2] The Board notes that Dr. Hakim did not respond to the Office's request to submit his December 5, 1998 medical records.

[3] *See John J. Carlone*, 41 ECAB 354 (1989).

[4] *Carmen Dickerson*, 36 ECAB 409 (1985); *Joseph A. Fournier*, 35 ECAB 1175 (1984); *see also George W. Glavis*, 5 ECAB 363 (1953).

In this case, the Office found that there were such inconsistencies in the evidence as to cast doubt that the incident occurred as alleged. Appellant has consistently maintained that, on December 2, 1998 she hurt her back while moving office supplies and equipment to her new office. Dr. Fang's August 7, 2001 report indicated a history that appellant hurt her back while lifting heavy boxes of files and binders and heavy equipment on December 2, 1998. Similarly, Dr. Hakim's August 20, 2001 report and Dr. Prinz's August 28, 2001 report provided a history that appellant hurt her back while lifting and moving heavy boxes and office equipment on December 2, 1998. He noted that he treated appellant on December 5, 1998, which was contemporaneous to the alleged incident. Dr. Soeken provided a history that appellant hurt her back on December 2, 1998 while moving her office supplies and computer.

The Board finds that the statements of appellant and the reports of Drs. Fang, Prinz and Soeken are sufficient to establish that the December 2, 1998 incident occurred as alleged. Further, although Dr. Hakim did not submit an actual report regarding his treatment of appellant on December 5, 1998 as requested by the Office, his statement that he treated appellant on that date supports that the incident occurred as alleged.

The second component of fact of injury is whether the employment incident caused a personal injury and generally it can be established only by medical evidence. The medical evidence required to establish causal relationship is usually rationalized medical evidence. Rationalized medical opinion evidence is medical evidence, which includes a physician's rationalized opinion on the issue of whether there is a 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.[5]

In this case, appellant has not submitted a rationalized, probative medical opinion sufficient to demonstrate that her December 2, 1998 employment incident caused a personal injury or resultant disability. The MRI reports from Drs. Huang, Monteferrante and Samtani, Dr. Burgess' report and Dr. Long's x-ray report are insufficient to establish appellant's burden because they predate the December 2, 1998 employment incident.

Dr. Jackson's January 14 and September 23, 1999 reports and Dr. Hakim's August 28, 2001 report are insufficient to establish appellant's burden because they failed to address whether appellant sustained a medical condition or resultant disability due to the December 2, 1998 employment incident.

The opinion of Drs. Fang and Soeken that appellant's May 1995 injury was aggravated by moving and carrying heavy boxes and office equipment on December 2, 1998 is insufficient to satisfy appellant's burden. As a licensed acupuncturist, Dr. Fang is not considered a physician under the Federal Employees' Compensation Act.[6] Similarly, Dr. Soeken, as a psychotherapist,

[5] *John J. Carlone*, *supra* note 3.

[6] 5 U.S.C. § 8101(2); *Sheila A. Johnson*, 46 ECAB 323 (1994).

is not a physician or clinical psychologist as defined under the Act.[7] Thus, their opinions regarding any injury are of no probative medical value.

Dr. Jackson's opinion, that appellant's 1995 back injury was aggravated by the December 2, 1998 employment incident and that she was totally disabled, failed to provide any medical rationale explaining how or why appellant's back condition and resultant disability were due to the above employment incident. Similarly, Dr. Hakim's August 20, 2001 report, indicating that appellant sustained additional trauma due to lifting and moving heavy boxes and office equipment and that she was permanently disabled, failed to provide any medical rationale explaining how appellant's back condition was aggravated by the December 2, 1998 employment incident.

The Office advised appellant of the type of evidence required to establish her claim; however, appellant failed to submit such evidence. Appellant, therefore, did not provide a medical opinion to describe or explain the medical process through which the December 2, 1998 employment incident would have caused the claimed injury. Accordingly, as appellant failed to submit any probative medical evidence establishing that she sustained an injury in the performance of duty, the Office properly denied appellant's claim for compensation.

The September 4, 2002 decision of the Office of Workers' Compensation Programs is hereby affirmed.

Dated, Washington, DC
April 7, 2003

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

[7] 5 U.S.C. § 8101(2).