United States Department of Labor
Employees' Compensation Appeals Board

J.C., Appellant	)	
and	)	**Docket No. 10-1491**
	)	**Issued: March 23, 2011**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRATION, NORTH CHICAGO VETERANS MEDICAL CENTER, North Chicago, IL, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On May 11, 2010 appellant, through his attorney, filed a timely appeal from a March 30, 2010 merit decision of the Office of Workers' Compensation Programs denying his claim. Pursuant to the Federal Employees' Compensation Act[1] 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 meet his burden of proof to establish that he sustained a back or groin injury on June 6, 2008, as alleged.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On September 16, 2008 appellant, then a 30-year-old housekeeping aid, filed a traumatic injury claim alleging an injury to his back and groin area on June 6, 2008 when he twisted while pulling two carts to the surgery area. He was off work from June 9 through 23, 2008 and returned to light duty on June 24, 2008. Appellant stopped work again on July 3, 2008 and returned to light duty on September 15, 2008.[2]

Evidence submitted with the claim included an October 8, 2008 statement from appellant, leave analysis, medical notes from the employing establishment's health unit dated October 17, 2008 and March 31, 2009. A June 24, 2008 lumbar spine magnetic resonance imaging (MRI) scan report showed multilevel disc annular bulging with mild stenosis and bilateral foraninal narrowing. Appellant submitted several requests for functional capacity evaluation and work restrictions dated June 10, 2008 to June 14, 2009.

In an August 5, 2008 report, Dr. Reuben R. Weisz, a Board-certified neurologist, noted a history of diabetes and gastroesophageal reflux disease (GERD). He reported that appellant was being evaluated for low back pain radiating down both legs and to the testicles, which had been present for two and a half months. Dr. Weisz opined that appellant had lumbosacral radiculopathy with possible peripheral neuropathy. In an August 13, 2008 report, he stated that an electromyogram (EMG) was consistent with bilateral L4 and S1 radiculopathy.

By letter dated August 26, 2009, the Office requested additional factual and medical evidence from appellant. Appellant was asked to provide an opinion from a physician which contained a well-rationalized opinion supported by objective evidence as to how the claimed injury resulted in his back condition. No additional evidence was submitted.

By decision dated October 7, 2009, the Office denied appellant's claim finding that the medical evidence was insufficient to establish that his back condition was caused by the June 6, 2008 twisting employment incident.

Counsel requested a telephonic hearing that was held on January 13, 2010. Appellant testified that he had a prior work injury to his back, but in the year preceding the present claimed injury, he had not had any problems with his back. When injured on June 6, 2008, he did not feel pain until the next day. Appellant sent an e-mail to the employing establishment's health unit and advised his supervisor by voicemail about the injury the following day. He saw several physicians for his work injury. Appellant missed intermittent time from work and was fired on November 6, 2009 as it did not appear he would recover from his back injury.[3]

Appellant's attending physician, Dr. Joseph H. Mun, a Board-certified internist, submitted reports dated March 29, 2006 through January 13, 2010. In a June 10, 2008 report,

[2] The claim was initially considered a short-term closure case and medical bills were authorized up to $1,500.00. However, the Office opened the case for adjudication when appellant's expenses exceeded that amount.

[3] The Office hearing representative noted that the medical records from the employing establishment's health unit indicated appellant sought care for a new injury to his upper back in March 2009 and for his low back in June 2009. Appellant was advised that he should file new claims for both of those incidents.

Dr. Mun made no reference to the June 6, 2008 incident or back and groin pain. A prescription note of June 10, 2008 stated, "P[atien]t should be on light duty tentatively through June 24, 2008." On June 21, 2008 Dr. Mun noted appellant had testicular pain and low back pain for the prior three weeks. He assessed low back pain/testicular pain and possible neurogenic thigh pain. On August 8, 2008 Dr. Mun noted appellant had right leg neuropathic pain and was seen by Dr. Weisz and had an EMG. He assessed nausea, most likely due to diabetic gastroparesis better controlled diabetes and peripheral neuropathy. Subsequent reports provide assessments of bilateral lower extremity pain and peripheral neuropathy.

The emergency room records from Vista Medical Center-East were submitted. In a June 9, 2008 report, Dr. Il Yoo, Board-certified in emergency medicine, noted that appellant presented with testicular pain and swelling which began four days prior. He listed a clinical impression of testicular pain and acute orchitis. In a July 7, 2008 emergency room report, Dr. Gregory Cowell, a Board-certified internist, advised that appellant presented with testicular pain and groin pain, he stated was present since June 6, 2008 and was previously seen for the same pain. Nursing notes reported the onset of symptoms as two months prior that had not improved after an emergency department visit last month and a visit to his doctor. Leg pain was noted. A clinical impression of acute orchitis and acute epididymitis was made by Dr. Cowell.

On July 10, 2008 appellant was seen by Dr. Raza M. Khan, a Board-certified urologist, who assessed back pain and bilateral orchialgia. In a July 17, 2008 report, Dr. Khan noted seeing him for bilateral orchialgia and back pain. Clinical examination was unremarkable with normal testes and epididymides. Dr. Khan opined that appellant might have pain from back problems and referred him to a neurologist.

On July 18, 2008 appellant was hospitalized for chest pain. He was noted to have intermittent testicular pain with pain and numbness to the lower extremities, bilaterally. The medical history revealed Type II diabetes and degenerative changes of the lumbar spine with probable peripheral neuropathy. Dr. Corey Black, a Board-certified internist, listed atypical chest pain, shortness of breath, weight loss and neuropathic pain in both lower extremities. On July 19, 2008 he noted that appellant had a two-month history of testicular and bilateral anterior thigh pain for which he has seen his primary care physician. Dr. Black advised that appellant had an MRI scan of the low back which showed degenerative changes and that appellant would see a neurologist to evaluate for neuropathy.

On August 21, 2008 appellant saw Dr. Anatoly Arber, Board-certified in anesthesiology and pain management. In the patient intake form, he indicated that he hurt himself at work two months prior while pulling carts and picking up soiled linen. The pain was to appellant's back, legs, feet, arms as well as in his groin and testicles. Dr. Arber noted that appellant's symptoms had been present from two to three months. While appellant was not sure of the cause, he attributed it to heavy work. Dr. Arber administered a lumbar epidural steroid injection for intractable low back pain.

Appellant was referred by Dr. Mun to Dr. Mark Trelka, a Board-certified neurologist. On September 23, 2008 Dr. Trelka obtained a history of chronic back pain that began at work in mid-June when appellant twisted his back while delivering two heavy linen carts. He stated appellant immediately had pain in the low back or belt line area and in the groin or testicular

area, but finished work as only 10 minutes remained. Appellant did not work the next day and the pain continued on a constant daily basis. Dr. Trelka noted a lumbosacral spine MRI scan taken demonstrated multilevel disc annulus bulge, mild acquired central canal stenosis and bilateral neuroforaminal narrowing. Appellant was seen in an emergency room in late June 2008 by Dr. Khan for evaluation of the groin and testicular pain. A July 20, 2008 abdominal computerized tomography (CT) scan showed prostatic calcifications. Dr. Trelka noted appellant was evaluated for weight loss, low back pain and pain management. The EMG and nerve conduction velocity (NCV) studies demonstrated bilateral S1 and L4 radiculopathies. Dr. Trelka stated that appellant's physicial examination was essentially normal. He stated that appellant injured his back while at work and that the lower back and bilateral lower extremity pain was probably due to the radiculopathies demonstrated on the EMG/NCV while the pain in the mid and upper back areas were probably due to a musculoskeletal pain syndrome.

Dr. Anwuli Okoli, a Board-certified anesthesiologist and Board-certified pain management specialist, noted, in an October 10, 2008 report, that appellant's lower extremity pain started about four months prior due to an injury at work. Appellant had seen a neurologist, a pain management specialist and a primary care physician for his pain and had epidural steroids and tried narcotics. Tenderness was noted in the paraspinal region, facet tenderness. Reflexes and motor strength were normal. In an October 14, 2008 report, Dr. Okoli noted that the MRI scan revealed bulging discs and EMG/NVC study revealed L4 and S1 radiculopathies. He provided a lumbar epidural steroid injection.

Various diagnostic test reports from 2008 were also submitted.

By decision dated March 30, 2010, an Office hearing representative affirmed the denial of appellant's claim finding that the medical evidence was not sufficient to establish that his claimed back condition was caused by the June 6, 2008 work incident.

LEGAL PRECEDENT

An employee seeking benefits under the Act[4] has the burden of establishing 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 the Act, that the claim was filed within the applicable time limitation of the Act, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury. These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[5]

In order to determine whether an employee actually sustained an injury in the performance of duty, the Office begins with an analysis of whether fact of injury has been established. Generally, fact of injury consists of two components which must be considered in conjunction with one another. The first component to be established is that the employee

[4] 5 U.S.C. §§ 8101-8193.

[5] *Gary J. Watling*, 52 ECAB 357 (2001).

actually experienced the employment incident which is alleged to have occurred.[6] The second component is whether the employment incident caused a personal injury and generally can be established only by medical evidence. To establish a causal relationship between the condition, as well as any attendant disability claimed and the employment event or incident, the employee must submit rationalized medical opinion evidence, based on a complete factual and medical background, supporting such a causal relationship.[7]

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.[8] The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.[9]

ANALYSIS

Appellant alleged that he sustained an injury to his groin area and back on June 6, 2008 when he twisted while pulling two carts to the surgery unit. The evidence supports that this incident occurred as alleged. The Board finds that the medical evidence of record is insufficient to establish that appellant sustained an injury causally related to the June 6, 2008 work incident.

In a September 23, 2008 report, Dr. Trelka advised appellant's chronic back pain began in mid-June while at work when he twisted his back while delivering two heavy linen carts. He reviewed appellant's medical records and stated that the clinical examination was essentially normal. Dr. Trelka stated that appellant injured his back while at work. He opined that the low back and bilateral lower extremity pain appellant experienced was probably due to bilateral S1 and L4 radiculopathies and that pain in the mid and upper back areas was probably due to a musculoskeletal pain syndrome. In addressing causal relationship, however, Dr. Trelka largely repeated the occupational history as reported by appellant without providing a reasoned opinion addressing how the accepted incident at work would cause or contribute to the diagnosed radiculopathies or musculoskeletal pain syndrome. He did not otherwise explain the reasons why the June 6, 2008 work incident caused or aggravated the conditions for which he treated appellant. Dr. Trelka also did not explain why appellant would remain symptomatic in light as essentially normal physical examination. His opinion that the conditions were probably due to the work incident is speculative and not fully explained, especially with regards to appellant's prior history of injury and treatment.

[6] *Michael E. Smith*, 50 ECAB 313 (1999).

[7] *Id.*

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

[9] *Franklin D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value); *Jimmie H. Duckett*, 52 ECAB 332 (2001).

In his August 21, 2008 report, Dr. Arber noted that appellant related hurting himself at work two months prior while pulling carts and picking up soiled linen. He reported appellant's belief that his back and groin pain was work related. Dr. Arber did not provide his own reasoned opinion explaining how appellant's activities at work on June 6, 2008 caused or aggravated the back or groin condition. This does not constitute a rationalized medical opinion and is insufficient to establish causation.[10] In an October 10, 2008 report, Dr. Okoli noted appellant's lower extremity pain started four months earlier due to an injury at work, but Dr. Okoli did not identify the work incident that caused injury or provide medical rationale to explain how twisting on June 6, 2008 caused or aggravated a diagnosed condition. Neither physician made reference to appellant's preexisting back condition.

Appellant submitted several reports from his treating physician, Dr. Mun. On June 10, 2008 Dr. Mun made no reference to a work incident or to back or groin pain. He provided no reference as to why he put appellant on light duty. On June 21, 2008 Dr. Mun noted that appellant had testicular pain and low back pain for the prior three weeks. He listed diagnoses but did not discuss the cause of appellant's conditions or address any relationship between the condition for which he treated him and the accepted June 6, 2008 work incident. The reports of Dr. Mun are of diminished probative value and insufficient to meet appellant's burden of proof.[11]

The emergency room reports from Drs. Yoo and Cowell are similarly insufficient to establish the claim. Neither physician supported that the June 6, 2008 work incident caused or aggravated a diagnosed back or groin condition. The reports from Drs. Khan and Weisz noted appellant's complaints and status but did not provide any opinion on causal relationship. The remainder of the medical evidence, including the MRI scan, EMG/NCV studies and CT scans, is insufficient to establish the claim as the diagnostic studies do not address causal relationship.

The Board finds that the medical evidence of record does not provide a fully rationalized medical opinion, based on a full or accurate history explaining the reasons why the June 6, 2008 work incident caused or aggravated the claimed medical conditions. Appellant did not meet his burden of proof to establish that the June 8, 2008 work incident caused or aggravated a back or groin condition.

CONCLUSION

The Board finds that appellant failed to meet his burden of proof to establish that he sustained a back or groin injury causally related to his June 6, 2008 employment incident.

[10] Appellant's belief that the employment caused or aggravated his condition is insufficient to establish causal relationship. *See Joseph T. Gulla*, 36 ECAB 516 (1985).

[11] Medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship. *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated March 30, 2010 is affirmed.

Issued: March 23, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board