United States Department of Labor
Employees' Compensation Appeals Board

D.H., Appellant	)	
and	)	**Docket No. 10-1981**
	)	**Issued: May 16, 2011**
U.S. POSTAL SERVICE, POST OFFICE, Monroe, MI, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On July 20, 2010 appellant, through her representative, filed a timely appeal from March 18 and June 3, 2010 merit decisions of the Office of Workers' Compensation Programs denying her traumatic injury claim. Pursuant to the Federal Employees' Compensation Act[1] 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 established that she sustained an employment-related back and hip injury on January 30, 2009.

FACTUAL HISTORY

On July 31, 2009 appellant, then a 43-year-old clerk, filed a traumatic injury claim alleging that on January 30, 2009 she experienced chronic pain in her back and hip as a result of unloading a semi-truck of very heavy pallets with phonebooks. She stopped work on January 31,

[1] 5 U.S.C. § 8101 *et seq.*

2009 and returned to work intermittently thereafter. The employing establishment controverted appellant's claim on the grounds that she was not injured in the performance of duty. Appellant's supervisor stated that she complained of preexisting back pain and never reported a work-related injury until she had no leave left from being off work since January 31, 2009.

In a December 6, 2007 work excuse slip, Dr. Wilson S. Yap Pueying, a family practitioner, noted that appellant was unable to work from December 6 to 9, 2007. He diagnosed her with strained muscle, pinched nerve and an illegible condition. In a handwritten December 3, 2007 prescription slip, Dr. Pueying reported that appellant was unable to work from December 3 to 5, 2007 and also contained an illegible diagnosis.

The employing establishment provided additional work excuse slips from unknown providers dated June 29 and July 29, 2009 excusing appellant from work from June 29 to September 30, 2009. Appellant was diagnosed with chronic low back, right hip and right sacroiliac (SI) pain.

In a letter dated August 13, 2009, the Office advised appellant that the evidence submitted was insufficient to support her claim. It requested that she provide evidence supporting that she provided timely notification, establishing that she actually experienced the employment incident as alleged and demonstrating that she was injured in the performance of duty. The Office also requested that appellant provide a comprehensive, narrative medical report with a history of injury, a firm diagnosis of any condition, symptoms, test findings and results, treatment provided, prognosis and a physician's opinion explaining why the condition was believed to have been caused or aggravated by the alleged employment incident. Appellant did not respond.

In a decision dated September 16, 2009, the Office denied appellant's claim finding that she failed to establish fact of injury. It determined that the evidence failed to demonstrate that the alleged January 30, 2009 incident occurred or that any diagnosed condition resulted from the alleged incident.

Appellant provided several magnetic resonance imaging (MRI) scan reports of her hip and back. In an April 1, 2009 report interpreted by Dr. Rachel Hulen, a Board-certified diagnostic radiologist, appellant was described as a 43-year-old female suffering from back pain. She observed that appellant's vertebral body heights were preserved, but her intervertebral disc spaces were narrowed at L4-L5 and L5-S1 with Grade 1 retrolisthesis of L3 on L4. Dr. Hulen also noted endplate and facet degenerative changes in the lower lumbar spine and diagnosed degenerative disc disease and facet arthropathy of the lower lumbar spine with a Grade 1 retrolisthesis of L3 on L4.

In an August 16, 2009 MRI scan report of appellant's hip, Dr. Hulen diagnosed mild or early right hip osteoarthritis. She observed minimal spurring of appellant's femoral head without significant joint space loss and no signal abnormality to suggest avascular necrosis or fracture. Dr. Hulen also noted that appellant's synovium was within normal limits with no joint effusion and that her visualized bursae and neurovascular structures were unremarkable and intact.

On August 30, 2009 appellant underwent an MRI scan of her lumbar spine interpreted by Dr. Todd Aho, a Board-certified diagnostic radiologist who specializes in neuroradiology. Dr. Aho observed that her marrow signal, vertebral body heights and alignment were normal but her L3-L4 had very mild facet degenerative change without focal disc disease or stenosis; her L4-L5 had minimal bilateral facet degenerative change and slight disc bulging and her L5-S1 had mild bilateral foot face degenerative change without disc disease or stenosis. He diagnosed a minor degree of spondylitic change within the lumbar spine without a central canal stenosis or exiting nerve root compression at any level.

In an April 1, 2009 medical report Dr. Shlomo Mandel, Board-certified in internal and occupational medicine, noted appellant's complaints of chronic low back pain in her right side that she experienced off and on for the prior year and which worsened in the last six weeks. Appellant reported working for the employing establishment which involved heavy lifting and unloading of trucks but denied any particular injury, accident or trauma. She underwent physical therapy for the prior four weeks with no success. Dr. Mandel obtained an x-ray evaluation and found no significant arthropathy or disc space narrowing. He reviewed a February 2009 MRI scan report that appellant brought from an outside hospital and observed that her lumbar spine was unremarkable without evidence of disc bulging, herniation, central canal stenosis, nerve root impingement or significant facet arthropathy.

In an April 1, 2009 medical form, appellant described her pain level and noted that she experienced the most pain in her right hip. She noted that the pain was not related to an injury. Appellant stated that she worked for the postal service for 11 years loading and unloading trucks and working window sales.

In a May 14, 2009 medical report Dr. Sarah Yovino, a Board-certified anesthesiologist, who specializes in pain medicine, advised that appellant complained of right low back and hip pain, which started a couple of years ago but significantly worsened since February 2009. Appellant described the pain as stabbing and aching with some numbness in the right gluteal region. She stated that rest relieved the pain, but sitting or standing for long periods of time exacerbated it. Appellant's treatments had included physical therapy for six weeks and cortisone shots. Dr. Yovino noted that appellant worked for the employing establishment but left because of pain. She reviewed appellant's MRI scan results and observed degenerative disc disease and facet arthropathy of the lower lumber spine with Grade 1 retrolisthesis of L3 on L4. Appellant's straight-leg raise test was negative bilaterally and her Patrick's test was mild positively on the right, negative on the left. Dr. Yovino diagnosed her with facet arthropathy of the lower lumbar spine.

Appellant also provided several medical notes regarding her treatments for lower back and right hip pain. In a June 26, 2009 medical report, Dr. Henry Kroll, a Board-certified anesthesiologist, who specializes in pain medicine, diagnosed facet syndrome of the lower lumbar spine and spondylosis. He described an intraarticular facet steroid injection and obtaining an arthrogram. Dr. Kroll included a handwritten outpatient procedure record, which noted that appellant was treated for hip pain and received a steroid injection on the right side.

In a July 13, 2009 report, Dr. David Kim, Board-certified in physical medicine and rehabilitation with a specialty in pain medicine, confirmed that he saw appellant for complaint of

pain primarily in the right SI, extending laterally to the hips and in the hip area with internal and external rotation. Appellant tested positive for Patrick's test on the right and left side with tenderness. Dr. Kim also provided a procedure treatment note, which diagnosed sacroilitis and described a right SI joint steroid injection and arthrogram.

In a September 9, 2009 procedure note Dr. Nabil Sibai, a Board-certified anesthesiologist, who specializes in pain medicine, noted that appellant was seen for a right SI joint injection. He diagnosed sacroilitis and she underwent a bilateral SI joint steroid injection and arthrogram.

In a September 17, 2009 letter, Dr. Pueying stated that appellant was initially seen on February 2, 2009 for severe right SI pain with moderate tenderness at the area. Appellant received a trigger point injection of cortisone to the right SI joint, which provided her relief for one week. When she returned, Dr. Pueying scheduled an MRI scan of her spine. He reported that appellant attended physical therapy and rehabilitation and received pain blocks from a pain clinic, but the treatments were all unsuccessful. Dr. Pueying noted that her work required heavy lifting, bending and prolonged standing at times.

On December 28, 2009 appellant filed a request for reconsideration on the grounds that her physician did not respond within 30 days to a request for her medical records. She resubmitted several medical documents[2] and provided an unsigned, undated statement. Appellant explained that she did not file a claim within 30 days of injury because she was unaware of the 30-day time limitation and thought she would be unable to work for only a short time. She thought her job would be in jeopardy if she reported an injury because she witnessed other employees who were reprimanded after being injured.

On January 12, 2010 the Office advised the employing establishment that appellant requested reconsideration and inquired as to any comments or documents which might be relevant to her claim. By letter dated January 15, 2010, the employer responded contending that she mentioned a preexisting back condition and failed to immediately report the alleged January 30, 2009 injury. The employing establishment explained that appellant worked the retail window for the majority of time. Appellant did not make any claims regarding pain or injury until she started working in the dispatch area. The employing establishment contended that she filed this claim because she ran out of sick and annual leave. It also refuted appellant's statement that she was afraid to file because of past action taken against employees who filed compensation claims.

By decision dated March 18, 2010, the Office modified its September 16, 2009 decision. It found that the January 30, 2009 incident occurred as alleged but denied the claim due to insufficient medical evidence to establish that appellant's back condition was causally related to the incident at work.

[2] Appellant resubmitted the April 1, 2009 referral by Dr. Pueying, the April 1 and August 18, 2009 MRI scan results interpreted by Dr. Hulen, the April 1, 2009 medical record by Dr. Mandel, the May 14, 2009 medical report by Dr. Yovino, the July 13, 2009 medical record by Dr. Kim, the August 31, 2009 MRI scan results interpreted by Dr. Aho and the September 9, 2009 note from Dr. Sibai.

On May 6, 2010 appellant requested reconsideration of the Office's March 18, 2010 decision. In the April 28, 2010 letter, Dr. Pueying stated that she was his patient since February 2, 2009 for back pain. Appellant alleged that she was working and lifting heavy pallets of phonebooks prior to her pain, which most likely caused and triggered this protracted and chronic pain. Dr. Pueying explained that she tried different treatments but had not obtained any relief and that prolonged standing, frequent bending and prolonged sitting worsened her pain.

In a decision dated June 3, 2010, the Office found that the medical evidence was insufficient to establish that appellant sustained a back condition causally related to the January 30, 2009 employment incident.

LEGAL PRECEDENT

An employee seeking benefits under the Act has the burden of proof to establish the essential elements of her claim by the weight of the reliable, probative and substantial evidence[3] including that she sustained an injury in the performance of duty and that any specific condition or disability for work for which she claims compensation is causally related to that employment injury.[4]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether "fact of injury" has been established.[5] There are two components involved in establishing fact of injury. 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.[6] Second, the employee must submit evidence, generally only in the form of probative medical evidence, to establish that the employment incident caused a personal injury.[7]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[8] Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on whether there is a causal relationship between the employee's diagnosed condition and the specified employment factors or incident.[9] The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable medical

[3] *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

[4] *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989); *M.M.*, Docket No. 08-1510 (issued November 25, 2010).

[5] *S.P.*, 59 ECAB 184 (2007); *Alvin V. Gadd*, 57 ECAB 172 (2005).

[6] *Bonnie A. Contreras*, 57 ECAB 364 (2006); *Edward C. Lawrence*, 19 ECAB 442 (1968).

[7] *David Apgar*, 57 ECAB 137 (2005); *John J. Carlone*, 41 ECAB 354 (1989).

[8] *D.I.*, 59 ECAB 158 (2007); *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *W.D.*, Docket No. 09-658 (issued October 22, 2009).

[9] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

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 employee.[10]

ANALYSIS

The Office accepted that on January 30, 2009 appellant unloaded a semi-truck of very heavy pallets with phonebooks. The issue is whether appellant established that her claimed back and hip conditions resulted from the January 30, 2009 employment incident.

Appellant provided several MRI scan reports interpreted by Dr. Hulen and Dr. Aho that diagnosed degenerative disc disease, facet arthropathy of the lower lumbar spine, mild or early right hip osteoarthritis and minor spondylitic changes within the lumbar spine. She also provided treatment notes from Drs. Kim, Kroll and Sibai describing the steroid injections she received for lower back pain providing diagnoses of facet syndrome, spondylosis and sacroilitis. While these reports contained firm diagnoses based on objective findings, they do not address the causal relation of these medical conditions to the January 30, 2009 incident at work. The reports failed to provide a history of injury describing a specific work incident or event connected to appellant's claimed conditions or any explanation as to how her back or right hip conditions related to her accepted incident. The physicians did not explain how she sustained her claimed conditions. Without a proper history of injury, the reports are not based upon a complete and factual background and are of limited probative value in establishing appellant's claim.[11]

In a May 14, 2009 report, Dr. Yovino diagnosed facet arthropathy of the lower lumbar spine and noted that appellant worked for the employing establishment. On April 1, 2009 Dr. Mandel noted appellant's complaints of chronic back pain and that she worked for the employing establishment. Although both physicians noted her history of prior back pain and that she worked at the employing establishment, neither physician mentioned the January 30, 2009 incident accepted in this claim or otherwise addressed the cause of appellant's claimed conditions. They failed to provide a rationalized medical opinion explaining how appellant's specific work duties on January 30, 2008 caused the claimed condition. As noted, reports lacking a proper history of injury or medical opinion regarding the cause of a claimant's condition are of limited probative value.[12] These reports also fail to establish fact of injury.

In a September 17, 2009 letter, Dr. Pueying stated that appellant was initially seen on February 2, 2009 for severe right SI pain and noted that her work required heavy lifting, bending and prolonged standing at times. On May 6, 2010 he reported that she was working and lifting heavy pallets of phonebooks prior to experiencing her pain, which most likely caused and triggered her protracted chronic pain. Dr. Pueying, however, did not provide a medical opinion which sufficiently explained the medical process through which the January 30, 2009 incident

[10] *B.B.*, 59 ECAB 234 (2007); *D.S.*, Docket No. 09-860 (issued November 2, 2009).

[11] *Paul Foster*, 56 ECAB 208 (2004); *J.F.*, Docket No. 09-1061 (issued November 17, 2009).

[12] *Id.; see also S.E.*, Docket No. 08-2214 (issued May 6, 2009).

would have caused the claimed injury.[13] Dr. Pueying did not provide a history of injury or state objective clinical findings for his opinion. While he mentioned appellant's work duties in general, he did not mention the January 30, 2009 incident or explain how lifting heavy pallets of phonebooks resulted in her claimed conditions.[14] In addition, Dr. Pueying's opinion that her work duties "most likely caused" her chronic pain is speculative in nature and of diminished probative value.[15] The Board finds that appellant submitted insufficient medical evidence to establish that she sustained an injury in the performance of duty.[16]

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that she sustained an injury on January 30, 2009 causally related to the accepted employment incident.

[13] *J.Z.*, 58 ECAB 529 (2007); *see also Thomas L. Hogan*, 47 ECAB 323 (1996).

[14] *T.H.*, 59 ECAB 388 (2008); *T.P.*, Docket No. 09-2102 (issued August 25, 2010).

[15] *A.D.*, 58 ECAB 149 (2006); *W.W.*, Docket No. 09-1619, (issued June 2, 2010).

[16] To the extent that medical evidence of record refers to repetitive lifting, bending and standing at work occurring over more than one shift, rather than a single incident and that appellant indicated on an April 1, 2009 form that her back pain was not related to a particular injury, the medical evidence implicates that she may have an occupational disease claim.

ORDER

IT IS HEREBY ORDERED THAT the June 3 and March 18, 2010 decisions of the Office of Workers' Compensation Programs be affirmed.

Issued: May 16, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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