United States Department of Labor
Employees' Compensation Appeals Board

S.C., Appellant	)	
and	)	**Docket No. 13-1164**
	)	**Issued: September 17, 2013**
DEPARTMENT OF HEALTH & HUMAN SERVICES, HEALTH SERVICE ADMINISTRATION, Oklahoma City, OK, 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
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On April 15, 2013 appellant, through counsel, filed a timely appeal from a March 7, 2013 merit decision of the Office of Workers' Compensation Programs (OWCP) denying her occupational disease claim. Pursuant to the Federal Employees' Compensation Act[1] (FECA) 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 met her burden of proof to establish that she developed a low back, left hip and left knee condition causally related to factors of her federal employment as a registered nurse.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On September 19, 2011 appellant, then a 60-year-old registered nurse, filed an occupational disease claim (Form CA-2) alleging that she developed a low back, left hip and left knee injury as a result of constant lifting and pulling and frequently repositioning and turning a patient.[2] She first became aware of her condition and of its relationship to her employment on August 11, 2011. Appellant stopped work and notified her supervisor on August 11, 2011. She was last exposed to the conditions from her employment on August 26, 2011.

In an attached narrative statement, appellant reported that she began to experience pain in her low back, abdomen and left hip area around August 6, 2011. The pain became progressively worse and she sought treatment on August 11, 2011. Appellant's physician informed her that she had injured her lower back. Appellant recalled lifting and pulling the week before but did not experience any discomfort at that time. Her physician informed her that symptoms might not appear until the injured area becomes swollen and inflamed.

In support of her claim, appellant submitted medical reports dated August 11, 17 and 25, 2011 from Dr. Charles C. Smith, a Doctor of Osteopathic Medicine, who reported that she complained of pain in the lower abdomen, lower back and right side of her back since Monday. Dr. Smith reported that a computerized tomography (CT) scan of the lumbar spine revealed partially occluded nerve root at L5-6 to the left. He diagnosed acute low back pain, lumbar disc herniation and nerve root compression at L5-S1 left. Dr. Smith reported that appellant could return to work on August 17, 2011 with limited duties. Appellant could walk and serve patients but could not lift or turn patients, squat, bend, rotate or lift more than 10 to 15 pounds. Dr. Smith recommended a magnetic resonance imaging (MRI) scan of the lumbar spine and a neurosurgical consult.

In a September 16, 2011 memorandum, Cindy Omary, appellant's supervisor, reported that appellant informed her that she did not think her condition was work related and she initially believed that she had a urinary tract infection (UTI).

By letter dated November 7, 2011, OWCP informed appellant that the evidence of record was insufficient to support her claim. Appellant was advised of the medical and factual evidence needed and was directed to submit it within 30 days.

In an August 11, 2011 CT scan of the lumbar spine, Dr. Nina C. Jones, a treating radiologist, reported that appellant revealed L5-S1 broad-based disc bulge with abutment of the exiting left nerve root. She further noted degenerative facet arthropathy at L4-5, L5-S1 and osteopenia.

In an August 17, 2011 progress note, Beverly Beatty, a Registered Nurse (RN), reported that appellant was evaluated regarding the work restrictions provided to her by Dr. Smith.

[2] The Board notes that appellant also filed a traumatic injury claim (Form CA-1) for an injury sustained on August 11, 2011. By letter dated November 22, 2011, OWCP provided clarification on what constitutes a traumatic injury and occupational disease claim. By letter dated November 30, 2011, appellant pursued her claim as an occupational injury, stating that her injury was not known until one to two weeks after it occurred.

RN Beatty reported that appellant was initially evaluated for a UTI but was told by Dr. Smith that she had a back injury and was placed on light duty. RN Beatty stated that specific information was required to assess what type of light-duty restrictions appellant needed and referred her to a walk-in clinic.

In a November 21, 2011 narrative statement, appellant reported that she believed her injury occurred while she was caring for a 49-year-old male Down's Syndrome patient who was very lethargic and required total care. She stated that she was assigned to this patient on July 30 and July 31, 2011 from 7:30 a.m. to 8:00 p.m. each day. Appellant assisted with all aspects of his care including turning, repositioning, pulling him up in bed, and cleaning him when he was incontinent. She also assisted the x-ray technician to obtain a portable chest x-ray at his bedside. Appellant reported that she did not recall feeling any incidence of pain during the times she cared for this patient. Approximately one week later on August 6, 2011, she began to experience pain in her low back, low abdomen and left hip area which worsened over the next few days. Appellant suspected she was developing a UTI and went to Claremore Indian Hospital Adult Walk-In Clinic on August 11, 2011 for treatment. She stated that she was examined by Dr. Charles Smith who ordered labs which revealed normal limits. Dr. Smith then ordered a CT scan of appellant's lumbar spine and informed her that she had injured her lower back. He asked her if she had been lifting or pulling a patient and she informed him that she had done so a week ago but did not recall experiencing any pain or discomfort at that time. Dr. Smith informed appellant that her injury was the type where she may not have known when it happened, as the symptoms for this type of injury commonly did not show until the affected area became swollen and inflamed as she was experiencing. Appellant reported no prior history of back pain or problems and no hobbies which could cause her condition.

By decision dated December 21, 2011, OWCP denied appellant's claim finding that the evidence of record failed to establish that the diagnosed condition was causally related to factors of her federal employment.

By letter dated December 29, 2011, appellant, through counsel, requested an oral hearing before the Branch of Hearings and Review.

At the March 21, 2012 hearing, appellant testified as to the prior allegations made in her narrative statement, arguing that her condition was caused by lifting and pulling patients and that her symptoms did not appear until a week later. She reported that Dr. Smith had not responded to her letter and that she was awaiting an additional report from him.

In an April 12, 2012 report, Dr. Smith reported that appellant felt a sudden onset of low back pain on or about August 11, 2011 after helping to move a patient who was in a hospital bed. Appellant's first symptoms seemed to be abdominal fullness. Upon physical examination and review of a CT scan of the lumbar spine, Dr. Smith diagnosed significant disc bulge at L5-S1 with apparent nerve root compression of the left nerve root. He noted that his initial diagnosis was that of L5-S1 radiculitis, acute. Appellant was treated with medication and returned on August 17 and 25, 2011 for follow-up visits when her pain continued. Dr. Smith noted that appellant had been off work for two weeks until August 25, 2011 but had recently somewhat increased her nursing work and contact with patients at the hospital. He also noted that an incidental emergency room (ER) record was found dated January 10, 2012 where appellant had

fallen out of a chair in which she was sitting and struck her buttocks on the floor. Diagnosis was only that of contusion to the buttocks area. Dr. Smith reported that his current impression as of the date of his April 12, 2012 report was that the LS-S1 left nerve root radiculitis seemed to have cleared leaving some apparent spinal cord pain issues that as of yet, were unaddressed. He noted that the pain pattern was of relatively low grade at the time and an MRI scan would clarify the issue. Dr. Smith recommended that appellant stay with relatively sedentary work without lifting, pushing or pulling more than 10 pounds on a repetitive basis.

By decision dated May 11, 2012, the Branch of Hearings and Review affirmed OWCP's December 21, 2011 decision finding that the evidence of record failed to establish that appellant's diagnosed conditions were causally related to factors of her federal employment.

By letter dated June 7, 2012, appellant, through counsel, requested reconsideration of the May 11, 2012 decision. Counsel stated that he was enclosing Dr. Smith's April 12, 2012 report and records from Dr. Troy A. Glaser, Board-certified in family medicine.

In a January 5, 2012 medical report, Dr. Glaser reported that appellant was a new patient who presented for low back pain which had been present for five months. Associated symptoms included tingling, stiffness, limited range of motion and catching. Appellant recalled no specific injury which was causing her pain and was currently employed as a nurse. Dr. Glaser noted that appellant was previously treated by Dr. Smith and underwent a CT scan of her lumbar spine in August 2011. He reviewed the August 2011 lumbar spine x-ray and agreed with the report of L5-S1 herniated disc compressing left S1 nerve root. Upon physical examination, Dr. Glaser diagnosed lumbar pain and radiculitis and recommended that appellant take two days off work.

In a January 6, 2012 report, Dr. Glaser reported that appellant underwent an MRI scan of the lumbar spine on January 5, 2012 which revealed L4-5 small disc protrusion into the left neuroforamen and L5-S1 disc protraction compressing thecal sac. He diagnosed lumbar radiculitis and lumbar disc displacement. Dr. Glaser provided appellant with treatment options and recommended that she return to work light duty with a weight restriction of 10 pounds.

By decision dated March 7, 2013, OWCP affirmed its May 11, 2012 decision finding that the evidence of record failed to establish that appellant's diagnosed conditions were causally related to factors of her federal employment as a registered nurse.

LEGAL PRECEDENT

An employee seeking benefits under FECA 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 FECA; that the claim was filed within the applicable time limitation; that an injury was sustained while in the performance of duty as alleged and that any disability or specific condition for which compensation is claimed is causally related to the

employment injury.[3] These are the essential elements of every compensation claim regardless of whether the claim is predicated on a traumatic injury or an occupational disease.[4]

In order to determine whether an employee actually sustained an injury in the performance of duty, OWCP 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 actually experienced the employment incident which is alleged to have occurred.[5] The second component is whether the employment incident caused a personal injury and generally can be established only by medical evidence.

To establish that an injury was sustained in the performance of duty in a claim for occupational disease, an employee must submit: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[6]

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] The opinion of the physician 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. This medical opinion must include an accurate history of the employee's employment injury and must explain how the condition is related to the injury. 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.[8]

ANALYSIS

OWCP accepted appellant's factors of federal employment as a registered nurse. It denied her claim, however, on the grounds that the evidence failed to establish a causal relationship between those activities and her diagnosed conditions. The Board finds that the medical evidence of record is insufficient to establish that appellant developed a lumbar condition causally related to factors of her federal employment as a registered nurse.

[3] *Gary J. Watling*, 52 ECAB 278 (2001); *Elaine Pendleton*, 40 ECAB 1143, 1154 (1989).

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

[5] *Elaine Pendleton*, *supra* note 3.

[6] *See Roy L. Humphrey*, 57 ECAB 238, 241 (2005); *Ruby I. Fish*, 46 ECAB 276, 279 (1994).

[7] *See* 20 C.F.R. § 10.110(a); *John M. Tornello*, 35 ECAB 234 (1983).

[8] *James Mack*, 43 ECAB 321 (1991).

In an August 11, 2011 diagnostic report, Dr. Jones reported that a CT scan of the lumbar spine revealed L5-S1 broad-based disc bulge with abutment of the exiting left nerve root, degenerative facet arthropathy at L4-5, L5-S1 and osteopenia. While Dr. Jones provides a diagnosis of appellant's condition, her report fails to state any opinion on causal relationship and is of limited probative value.[9]

In medical reports dated August 11 to 25, 2012, Dr. Smith reported that appellant first sought treatment on August 11, 2011 with complaints of pain in the lower abdomen, lower back and right side of back. He reported that a CT scan of the lumbar spine revealed partially occluded nerve root at L5-6 to the left. Dr. Smith diagnosed acute low back pain, lumbar disc herniation and nerve root compression at L5-S1 left. In an April 12, 2012 report, he reported that appellant felt a sudden onset of low back pain on or about August 11, 2011 after helping to move a patient who was in a hospital bed. Upon physical examination and review of a CT scan of the lumbar spine, Dr. Smith diagnosed significant disc bulge at L5-S1 with apparent nerve root compression of the left nerve root. He noted that his initial diagnosis was that of L5-S1 radiculitis, acute. Dr. Smith also noted that an incidental ER record was found dated January 10, 2012 where appellant was diagnosed with contusion to the buttocks area after she had fallen out of a chair in which she was sitting. He reported that his current impression as of this letter was that the LS-S1 left nerve root radiculitis seemed to have cleared leaving some apparent spinal cord pain issues that as of yet, were unaddressed. Dr. Smith recommended appellant stay with relatively sedentary work without lifting, pushing or pulling more than 10 pounds on a repetitive basis.

The Board finds that the opinion of Dr. Smith is not well rationalized. While Dr. Smith provided a diagnosis, none of his reports mentioned a work-related cause or aggravation of appellant's injuries. His statement that appellant felt a sudden onset of low back pain on or about August 11, 2011 after helping move a patient who was in a hospital bed is an insufficient opinion that appellant's employment factors caused or aggravated her conditions. Moreover, Dr. Smith did not adequately describe appellant's work duties and did not specify how often she was required to perform these tasks and the frequency of other physical movements. He merely recounted the incident as described by appellant and did not state how helping move a patient would cause the onset of low back pain. Dr. Smith also failed to provide a detailed and adequate medical history, only noting an ER visit in January 2012. The Board has held that 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.[10] Without medical reasoning explaining how appellant's employment factors caused her injuries, Dr. Smiths' reports are insufficient to meet appellant's burden of proof.[11]

In medical reports dated January 5 and 6, 2012, Dr. Glaser reported that appellant was a new patient who presented for low back pain which had been present for five months. Appellant recalled no specific injury which caused her pain. Dr. Glaser reviewed the August 2011 lumbar

[9] *S.E.*, Docket No. 08-2214 (issued May 6, 2009); *C.B.*, Docket No. 09-2027 (issued May 12, 2010).

[10] *Id.*

[11] *C.B.*, Docket No. 08-1583 (issued December 9, 2008).

spine x-ray and agreed with the report of L5-S1 herniated disc compressing left S1 nerve root. A January 5, 2012 MRI scan of the lumbar spine revealed L4-5 small disc protrusion into the left neuroforamen and L5-S1 disc protraction compressing thecal sac. Dr. Glaser diagnosed lumbar radiculitis and lumbar disc displacement. He provided appellant with treatment options and recommended she return to work light duty with a weight restriction of 10 pounds.

The Board notes that Dr. Glaser failed to provide an opinion on the cause of appellant's lumbar radiculitis and lumbar disc displacement or explain how her condition was caused or aggravated by her federal employment duties. Moreover, he did not provide an adequately detailed medical history or describe appellant's employment duties as a registered nurse. Medical reports without any rationale on causal relationship are of diminished probative value and do not meet an employee's burden of proof.[12] The opinion of a physician supporting causal relationship must rest on a complete factual and medical background supported by affirmative evidence, address the specific factual and medical evidence of record and provide medical rationale explaining the relationship between the diagnosed condition and the established incident or factor of employment.[13] Dr. Glaser's reports do not meet that standard and are insufficient to meet appellant's burden of proof.

In the instant case, the record lacks rationalized medical evidence establishing a causal relationship between appellant's lumbar condition and factors of her federal employment as a registered nurse. Thus, appellant has failed to meet her burden of proof.

Appellant may submit additional evidence, together with a written request for reconsideration, to OWCP within one year of the Board's merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.606 and 10.607.

CONCLUSION

The Board finds that appellant did not meet her burden of proof to establish that her lumbar condition is causally related to factors of her federal employment as a registered nurse.

[12] *Id.*

[13] *See Lee R. Haywood*, 48 ECAB 145 (1996).

ORDER

IT IS HEREBY ORDERED THAT the March 7, 2013 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 17, 2013
Washington, DC

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

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board