

ISSUE

The issue is whether appellant has met her burden of proof to establish a back condition causally related to the accepted December 18, 2016 employment incident.

FACTUAL HISTORY

On December 20, 2016 appellant, then a 46-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on December 18, 2016 she experienced lower left-sided back pain and left-sided sciatica when she twisted as she was transferring a heavy parcel from a long-life vehicle (LLV) to a dock while in the performance of duty. She stopped work on the filing date of her claim. On the reverse side of the claim form, the employing establishment controverted the claim, contending that the claimed injury was caused by appellant's own conduct as she knew the package was heavy because she obtained help to load it. It questioned why she had not gotten help to unload the package.

In an accompanying narrative statement, appellant reiterated her history of injury on December 18, 2016. She also reported that, after injuring herself, someone helped her put the parcel back by the correct route. Further, appellant indicated that, although she was limping, she went back out to deliver more parcels.

In support of her claim, appellant submitted medical reports and patient discharge instructions dated December 20, 2016 from Dr. Brian Piechowski, Board-certified in emergency medicine. Dr. Piechowski reported that on December 18, 2016 she turned and pulled something while taking a parcel off an LLV and placing it onto a dock. He described clinical findings and diagnosed acute left-sided low back pain with left-sided sciatica. Dr. Piechowski noted that the diagnosed condition was work related. He further noted that appellant was totally incapacitated and unable to work.

OWCP thereafter received a December 27, 2016 lumbar spine magnetic resonance imaging (MRI) scan report by Dr. Stephen J. Pomeranz, a Board-certified diagnostic radiologist. Dr. Pomeranz concluded that the MRI scan demonstrated satisfactory postoperative changes at L4-5. He also concluded that there were degenerative changes elsewhere. Dr. Pomeranz noted that at L3-4, there was mild anterolisthesis of L3 on L4. There was also concentric disc displacement with facet arthropathy and hypertrophy of the ligamentum flavum. Dr. Pomeranz determined that these findings in combination resulted in moderate bilateral lateral recess and neural foraminal narrowing without canal stenosis.

In a December 20, 2016 lumbar spine x-ray report, Dr. James E. Tomic, a Board-certified diagnostic radiologist, provided an impression of relatively pronounced chronic and postsurgical changes without frank acute bony abnormality.

In a December 22, 2016 report, Dr. Michael Didinsky, an attending Board-certified orthopedic surgeon, noted appellant's complaint of work-related left-sided low back and buttock pain. He further noted a history of injury that on December 18, 2016 she was moving a heavy parcel at work and she turned and twisted to set the package down, she felt immediate pain in her left buttock region that radiated into her left groin region. Appellant related to Dr. Didinsky that

she had been off work since her injury. Dr. Didinsky discussed findings on physical and x-ray examinations. He provided an impression of severe right buttock pain, either an L3 radicular pain versus post-traumatic sacroiliitis. Dr. Didinsky also provided an impression of degenerative lumbar scoliosis 41 degrees above a previous L4 through S1 fusion. He advised that appellant could return to sedentary work duties with restrictions. In a December 22, 2016 work release form, Dr. Didinsky indicated that her work status was temporary until her next appointment. On December 29, 2016 he reexamined appellant and provided an assessment of left post-traumatic sacroiliitis, noting that this was her likely diagnosis versus an atypical leg radiculopathy. On January 16, 2017 Dr. Didinsky reported a diagnosis of S1 joint dysfunction and ordered appellant to undergo a spine rehabilitation program, three times a week for four weeks.

In a report and return to work form dated December 22, 2016, Dr. James C. Foster, Board-certified in occupational medicine, noted a history of injury that on December 18, 2016 appellant injured her low back and buttock at work when she turned while lifting a package. He reported examination findings and diagnosed acute left lower back pain. Dr. Foster indicated that appellant was totally incapacitated and unable to work through December 29, 2016.

A January 17, 2017 report signed by a physical therapist noted appellant's diagnosis of lumbar S1 joint dysfunction and discussed her treatment.

OWCP, in a January 20, 2017 development letter, advised appellant that, when her claim was first received, it appeared to be a minor injury that resulted in minimal or no lost time from work. It further advised that, because she had not returned to full-time work, her claim would be formally adjudicated. OWCP also advised appellant of the type of medical evidence needed to establish her claim. It afforded her 30 days to submit the necessary medical evidence.

Daily notes dated January 17 through 30, 2017 were received from the same physical therapist who continued to note appellant's diagnosis of lumbar S1 joint dysfunction and discuss her treatment.

In additional work release forms dated December 27, 2016 and January 5, 2017, Dr. Didinsky reiterated his prior diagnosis of left S1 joint dysfunction. He also diagnosed low back pain with leg adenopathy. Dr. Didinsky advised that appellant was temporarily unable to work. In a procedure note dated January 4, 2017, he provided a preprocedure and postprocedure diagnosis of sacroiliitis/sacroiliac joint dysfunction and performed a sacroiliac injection under fluoroscopy. On January 31, 2017 Dr. Didinsky again diagnosed left S1 joint dysfunction and ordered a left S1 joint injection to be performed on February 3, 2017.

A report and work release form dated January 16, 2017 signed by Karen J. Stevens, a certified physician assistant, provided examination findings and diagnosed left post-traumatic sacroiliitis. She indicated that the diagnosed condition was work related. Ms. Stevens recommended that appellant remain off work until her next evaluation in four weeks.

By decision dated February 27, 2017, OWCP accepted that the December 18, 2016 employment incident occurred as alleged, that a medical condition had been diagnosed, and that appellant was in the performance of duty. However, it denied the claim finding that the medical evidence submitted was insufficient to establish that the diagnosed medical condition was causally

related to the accepted employment incident. OWCP concluded therefore that the requirements had not been met to establish an injury as defined by FECA.

OWCP continued to receive daily notes dated February 22 through March 2, 2017 from the same physical therapist.

OWCP also received an additional procedure note dated February 10, 2017 from Dr. Didinsky who continued to perform a left sacroiliac injection under fluoroscopy to treat appellant's sacroiliitis/sacroiliac joint dysfunction.

A February 16, 2017 report signed by Dana Stout, an advanced practice nurse practitioner, provided examination findings and diagnosed left post-traumatic sacroiliitis. She indicated that the diagnosed condition was work related.

In another report also dated December 20, 2016, Dr. Piechowski reiterated his prior diagnosis of acute left-sided low back pain with left-sided sciatica.

Ms. Stevens, in a March 16, 2017 report, again noted her diagnosis of work-related left post-traumatic sacroiliitis. In a work release form also dated March 16, 2017, she diagnosed left S1 joint dysfunction and noted that appellant could temporarily perform modified duties until her next appointment in four weeks.

On May 11, 2017 appellant requested reconsideration regarding the February 27, 2017 decision and submitted additional medical evidence.

In letters dated March 9 and 16, 2017, Dr. Didinsky opined that, based on his review of the medical record and examination findings that, to a reasonable degree of medical certainty, appellant's left buttock pain and left S1 joint post-traumatic sacroiliitis were directly caused by the accepted December 18, 2016 employment incident. Regarding the latter condition, he indicated that, if a different diagnosis was preferred, it would be sacroiliac sprain. In a May 19, 2017 procedure note, Dr. Didinsky performed a sacroiliac injection under fluoroscopy to treat appellant's sacroiliitis/sacroiliac joint dysfunction.

In a March 9, 2017 operative report, Dr. Michael J. Slimack, a Board-certified orthopedic surgeon, noted that appellant's preoperative and postoperative diagnosis was retained painful hardware, left patella. He performed a removal of a screw from the left patella.

In reports and work release forms dated April 13, May 11, and June 8, 2017, Ms. Stout diagnosed left S1 joint post-traumatic sacroiliitis/left S1 joint dysfunction and muscle spasms to the right flank. She indicated that these conditions were related to appellant's December 18, 2016 work injury. Ms. Stout initially advised that appellant could temporarily perform modified duties with restrictions and subsequently advised that she could return to full duties with no restrictions.

OWCP, by decision dated August 2, 2017, denied modification of its prior February 27, 2017 decision.

In a July 27, 2017 report, Dr. Didinsky discussed findings on physical and x-ray examination. He provided an assessment of right T10-T11 right-sided foraminal stenosis.

Dr. Didinsky also provided an assessment of unrelenting right inferior rib pain since last year, despite a cholecystectomy and an evaluation by several physicians and emergency room visits. In a letter dated August 31, 2017, he clarified his prior opinion on causal relationship. Dr. Didinsky noted that appellant underwent a previous L4 through S1 fusion in 2008 performed by Dr. Spencer J. Block, a neurosurgeon. He also noted that she had arthritic changes above the fusion area, including a degenerative scoliosis. Dr. Didinsky related that, prior to twisting while lifting the heavy parcel, appellant experienced immediate pain in her left buttock, which still bothered her. He indicated that, based on all the information he had and obtained from her, she did not have problems with left buttock pain prior to the lifting incident. Dr. Didinsky further indicated that S1 joint injections had helped significantly, albeit temporary relief. He believed that appellant was a candidate for left S1 joint radiofrequency or a stabilization procedure. Dr. Didinsky opined that the December 2016 injury was a direct cause of her left sacroiliitis. He recognized that appellant had a previous lumbar surgery and degenerative changes above the L4 through S1 fusion, however, he maintained that they did not appear to be the cause of her current symptoms. Therefore, Dr. Didinsky concluded that her work-related injury was the cause of her sacroiliitis and symptoms that necessitated a more aggressive intervention, including radiofrequency ablation and if that failed, then a S1 joint stabilization procedure.

In a procedure note dated August 1, 2017, Dr. Hardik A. Vashi, a Board-certified physiatrist, provided a preprocedure and postprocedure diagnosis of thoracic radiculopathy/spinal stenosis and performed an interlaminar epidural steroid injection under fluoroscopy.

Ms. Stout, in an August 17, 2017 report, provided an assessment of right T10-T11 right-sided foraminal stenosis that had improved with a right T10-T11 epidural steroid injection. She also provided an assessment of persistent sacroiliac joint pain.

In reports and progress notes dated September 11 through November 2, 2017, Dr. Foster provided assessments of status post fall, postconcussive syndrome, cervical strain, headache, cervicogenic aspect, anxiety, contusion/hematoma to the chin that was resolving, left knee contusion, and chronic back pain that temporarily aggravated a preexisting back condition.

On December 11, 2017 appellant requested reconsideration regarding the August 2, 2017 decision and resubmitted Dr. Didinsky's August 31, 2017 letter.

OWCP, by decision dated March 8, 2018, denied modification of its August 2, 2017 decision.

Appellant requested reconsideration on May 8, 2018.

In an April 20, 2018 letter, Dr. Didinsky noted that the most common causes of a S1 joint injury were twisting, turning, and lifting-type maneuvers. He advised that appellant's mechanism of injury was consistent with the mechanism capable of causing a S1 joint problem.

By decision dated August 8, 2018, OWCP again denied modification of its prior decisions.

OWCP received an August 31, 2018 report from Ms. Stevens who continued to diagnose work-related left S1 joint dysfunction.

Dr. Didinsky, in a January 17, 2019 letter, reiterated his prior opinion that appellant's left S1 joint post-traumatic sacroiliitis was caused by the December 18, 2016 employment incident. He also reiterated his explanation that a sacral injury usually occurred with a twisting, turning, and bending combination. Dr. Didinsky noted that appellant was asymptomatic in the S1 joint prior to these movements and became symptomatic after the stated work incident and received conservative care. He concluded that, within a reasonable degree of medical certainty, the work-related injury caused her sacroiliitis.

By decision dated April 5, 2019, OWCP again denied modification of its prior decisions.

LEGAL PRECEDENT

An employee seeking benefits under FECA³ has the burden of proof to establish 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 timely filed within the applicable time limitation period of FECA,⁴ and that an injury was sustained in the performance of duty as alleged, and that any disability or medical condition for which compensation is claimed is causally related to the employment injury.⁵ 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.⁶

To determine if an employee sustained a traumatic injury in the performance of duty, OWCP begins with an analysis of whether fact of injury has been established.⁷ There are two components that must be considered in conjunction with one another. The first component is whether the employee actually experienced the employment incident that allegedly occurred.⁸ The second component is whether the employment incident caused a personal injury.⁹

Causal relationship is a medical question that requires rationalized medical opinion evidence to resolve the issue.¹⁰ A physician's opinion on whether there is causal relationship between the diagnosed condition and the implicated employment incident must be based on a

³ *Id.*

⁴ *S.C.*, Docket No. 18-1242 (issued March 13, 2019); *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

⁵ *T.H.*, Docket No. 18-1736 (issued March 13, 2019); *J.M.*, Docket No. 17-0284 (issued February 7, 2018); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

⁶ *T.E.*, Docket No. 18-1595 (issued March 13, 2019); *K.M.*, Docket No. 15-1660 (issued September 16, 2016); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

⁷ *S.S.*, Docket No. 18-1488 (issued March 11, 2019); *T.H.*, 59 ECAB 388, 393-94 (2008).

⁸ *E.M.*, Docket No. 18-1599 (issued March 7, 2019); *Elaine Pendleton*, 40 ECAB 1143 (1989).

⁹ *E.M.*, *id.*; *John J. Carlone*, 41 ECAB 354 (1989).

¹⁰ *S.S.*, *supra* note 7; *Robert G. Morris*, 48 ECAB 238 (1996).

complete factual and medical background.¹¹ Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty, and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition, and appellant's specific employment incident.¹²

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish a back condition causally related to the accepted December 18, 2016 employment incident.

Appellant submitted a series of reports by Dr. Didinsky. In reports dated March 9 and 16, and August 31, 2017, April 20, 2018, and January 17, 2019, Dr. Didinsky opined that her left buttock pain and left S1 joint post-traumatic sacroiliitis and need to undergo left S1 joint radiofrequency or a stabilization procedure were directly caused by the accepted December 18, 2016 employment incident. He maintained that appellant's mechanism of injury was consistent with the mechanism that caused a S1 joint problem, which involved a combination of twisting, turning, lifting, and bending. Dr. Didinsky further maintained that, although she had undergone a L4 through S1 fusion in 2008 and subsequently developed arthritic changes above the fusion area that included degenerative scoliosis, the surgery and resultant condition did not appear to be the cause of her current conditions. He also maintained that appellant's left buttock pain had begun after the December 18, 2016 employment incident. The Board finds that, while his opinion is generally supportive of causal relationship, Dr. Didinsky has not provided adequate medical rationale explaining the basis of his opinion. The Board has held that a report is of limited probative value regarding causal relationship if it does not contain medical rationale explaining how a given medical condition/disability was related to employment factors.¹³ As such, the Board finds that Dr. Didinsky's March 9 and 16, and August 31, 2017, April 20, 2018, and January 17, 2019 reports are insufficient to meet appellant's burden of proof.

In his remaining reports, Dr. Didinsky reiterated the history of the accepted December 18, 2016 employment incident and his diagnosis of sacroiliitis/sacroiliac dysfunction. He also diagnosed severe right buttock pain, low back pain with leg adenopathy, and right T10-T11 right-sided foraminal stenosis. In addition, Dr. Didinsky addressed appellant's disability from work, and work restrictions. These additional reports do not contain a specific opinion as to the cause of the diagnosed conditions and resultant disability. The Board has held that medical evidence that does not offer an opinion regarding the cause of an employee's condition is of no probative value

¹¹ *C.F.*, Docket No. 18-0791 (issued February 26, 2019); *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

¹² *Id.*

¹³ *See Y.D.*, Docket No. 16-1896 (issued February 10, 2017) (finding that a report is of limited probative value regarding causal relationship if it does not contain medical rationale describing the relation between work factors and a diagnosed condition/disability).

on the issue of causal relationship.¹⁴ These reports therefore are insufficient to establish appellant's claim.

Likewise, the reports and progress notes from Drs. Foster, Slimack, and Vashi, which addressed appellant's back, head, cervical, chin, left knee, thoracic, and emotional conditions, disability from work, and medical treatment also are deficient as these reports and progress notes do not contain an opinion regarding causal relationship.¹⁵

While Dr. Piechowski opined, in reports and patient discharge instructions dated December 20, 2016, that appellant sustained acute left-sided low back pain with left-sided sciatica due to the December 20, 2016 employment incident and continued to be totally disabled from work, he failed to provide the necessary medical rationale to establish causal relationship. The Board has held that a report is of limited probative value regarding causal relationship if it does not contain medical rationale explaining how a given medical condition/disability was related to employment factors.¹⁶ Thus, the Board finds that Dr. Piechowski's reports are insufficient to establish appellant's claim.

Appellant submitted diagnostic test reports dated December 20 and 27, 2016 from Dr. Tomic and Dr. Pomeranz. The Board has held that diagnostic studies lack probative value on the issue of causal relationship as they do not address whether the employment incident caused any of the diagnosed conditions.¹⁷ Such reports are therefore insufficient to establish appellant's claim.

Appellant also submitted reports signed solely by a physician assistant or nurse practitioner, who found that she had left post-traumatic sacroiliitis due to the December 18, 2016 employment injury. The Board has held that medical reports signed solely by a physician assistant or nurse practitioner are of no probative value as physician assistants and nurse practitioner are not considered physicians as defined under FECA and are therefore not competent to render a medical opinion.¹⁸ These reports are therefore insufficient to establish the claim.

¹⁴ *F.D.*, Docket No. 19-0932 (issued October 3, 2019); *A.L.*, Docket No. 18-1756 (issued April 15, 2019); *K.E.*, Docket No. 18-1357 (issued March 26, 2019); *L.B.*, Docket No. 18-0533 (issued August 27, 2018).

¹⁵ *Id.*

¹⁶ *J.G.*, Docket No. 19-1116 (issued November 25, 2019); *Y.D.*, *supra* note 13.

¹⁷ *See F.D.*, *supra* note 14; *B.C.*, Docket No. 18-1735 (issued April 23, 2019); *J.S.*, Docket No. 17-1039 (issued October 6, 2017).

¹⁸ 5 U.S.C. § 8101(2) provides that a physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by state law. *See id.* at § 8102(2); 20 C.F.R. § 10.5(t); *T.W.*, Docket No. 19-0677 (issued August 16, 2019). Lay individuals such as physician assistants, nurses, and physical therapists are not competent to render a medical opinion under FECA. *S.P.*, Docket No. 19-0819 (issued January 10, 2020) (physician assistant); *C.S.*, Docket No. 19-1279 (issued December 30, 2019) (nurse practitioner).

As there is no well-reasoned medical opinion establishing appellant's claim for compensation the Board finds that she has not met her burden of proof.¹⁹

On appeal, counsel contends that OWCP failed to adjudicate the claim in accordance with the proper standard of causation and to give due deference to the findings of the attending physician. He has not, however, provided any evidence to support his arguments. As discussed above, Dr. Didinsky did not provide a rationalized opinion sufficient to establish that appellant's diagnosed back, buttock, leg, and thoracic conditions were caused or aggravated by the accepted December 18, 2016 employment incident.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128 and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish a back condition causally related to the accepted December 18, 2016 employment incident.

¹⁹ *F.D.*, *supra* note 14; *D.N.*, Docket No. 19-0070 (issued May 10, 2019); *R.B.*, Docket No. 18-1327 (issued December 31, 2018).

ORDER

IT IS HEREBY ORDERED THAT the April 5, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 4, 2020
Washington, DC

Christopher J. Godfrey, Deputy Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board