United States Department of Labor
Employees' Compensation Appeals Board

TC., Appellant	)	
and	)	**Docket No. 14-1406**
	)	**Issued: February 11, 2015**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA HOWARD FITZGERALD, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On June 5, 2014 appellant, through his attorney, timely appealed the March 20, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). 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 the claim.

ISSUES

The issues are: (1) whether appellant's claimed lumbar condition is causally related to his December 21, 2011 employment injury; and (2) whether OWCP properly terminated his wage-loss compensation and medical benefits effective May 16, 2012.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

This case was previously before the Board.[2] Appellant, a 46-year-old registered nurse, has an accepted traumatic injury claim for left mild patellar tendinitis, which arose on December 21, 2011.[3] He was using a foot pedal to manually raise a patient bed when he felt the bone in his left knee pop out of place. Appellant also claimed to have injured his lumbar spine on December 21, 2011. His lumbar-related diagnoses included left S1 radiculopathy, lumbar stenosis, and lower back and left leg paresthesia. With respect to appellant's accepted left knee condition, Dr. Peter C. Vitanzo, Jr., a Board-certified family practitioner with a subspecialty in sports medicine, released him to resume his regular nursing duties as of April 5, 2012.[4] However, appellant did not return to work at that time because of his lumbar condition.[5] He ultimately resumed his full-time, regular nursing duties on May 23, 2012. Approximately, one month later, appellant voluntarily resigned to pursue his education.[6]

When the case was last before the Board, OWCP had denied appellant's claim for an employment-related lumbar condition and had terminated wage-loss compensation and medical benefits with respect to appellant's accepted left knee condition. The Board set aside two decisions from the Branch of Hearings and Review dated September 26 and December 4, 2012. In both instances, the respective hearing representative overlooked December 2011 treatment notes from Dr. Sherita M. Latimore-Collier, an internist and appellant's spouse.[7] Because of this oversight, the Board found that the case was not in posture for decision.[8]

On remand, OWCP reviewed the record, including Dr. Latimore-Collier's December 2011 treatment notes and issued two decisions, both dated August 13, 2013. In one decision, it declined to accept appellant's lumbar condition as employment related. The other decision terminated wage-loss compensation and medical benefits effective May 16, 2012.

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[2] Docket No. 13-568 (issued July 12, 2013).

[3] A December 22, 2011 magnetic resonance imaging (MRI) scan revealed, *inter alia*, left knee mild patellar tendinitis, a small interstitial tear, and early patellar chondromalacia.

[4] Dr. Vitanzo initially examined appellant on February 16, 2012 and diagnosed left patellar tendinitis. He saw appellant for follow up on March 15, 2012, at which time he noted appellant's knee was not too bad. In an April 5, 2012 report, Dr. Vitanzo indicated that appellant was doing fine and was capable of resuming full-duty status with regard to his knee. Appellant had reached maximum medical improvement, and Dr. Vitanzo did not think any additional treatment was warranted for the knee. Dr. Vitanzo was aware that appellant was also being treated for a lumbar condition and deferred to appellant's other physician(s) regarding any lumbar-related work limitations.

[5] Appellant previously tried to resume work in a limited-duty capacity on February 21, 2012, but stopped work that same day.

[6] Appellant resigned effective June 22, 2012.

[7] Dr. Latimore-Collier examined appellant on December 21, 2011 for a work-related left knee injury, as well as complaints of radiating left leg pain and a burning sensation in his lower back. She also conducted a follow-up examination on December 27, 2011. In a report dated February 3, 2012, Dr. Latimore-Collier advised that the December 21, 2011 employment incident not only caused damage to appellant's left knee, but also compressed his S1 nerve root resulting in lower back pain radiating down his left leg into his left foot.

[8] The Board's July 12, 2013 order remanding case is incorporated herein by reference.

Appellant requested an oral hearing, which he later changed to a request for review of the written record.

By decision dated March 20, 2014, the hearing representative affirmed both August 13, 2013 decisions. She found that appellant failed to establish that he sustained a back injury on December 21, 2011. The hearing representative also found that OWCP met its burden to terminate wage-loss compensation and medical benefits with respect to appellant's accepted left knee condition.

As noted, Dr. Latimore-Collier examined appellant on December 21, 2011 for left knee, left leg, and lower back complaints following a work incident where he was "pumping bed with left foot." Appellant had already been seen at the employing establishment's occupational health unit.[9] A left knee x-ray was obtained, but the results were not yet available for Dr. Latimore-Collier's review. Dr. Latimore-Collier ordered a left knee MRI scan, prescribed tramadol for pain, and recommended heat and rest.

When appellant returned for follow up on December 27, 2011, Dr. Latimore-Collier noted that his pain had gotten worse. She also noted that an x-ray revealed a possible osteochondral lesion and a left knee MRI scan showed tendinitis and a possible meniscal tear. On physical examination, appellant's left knee was still tender on palpation and there was numbness down the left leg to his toes. Dr. Latimore-Collier also reported lower back tenderness. Her assessment was left knee trauma with neuropathic/radicular pain causing numbness of toes. Appellant also experienced numbness in his penis. Dr. Latimore-Collier prescribed both tramadol and Percocet for pain, and referred him to an orthopedic surgeon for further evaluation.

Dr. Michael F. Harrer, a Board-certified orthopedic surgeon, examined appellant on December 28, 2011. His initial impression was probable left lower back issue, creating left leg radiculopathy with minimal patella tendinitis of the left knee. Dr. Harrer explained that this all started when appellant was at work, manually pumping up a bed with a patient in it. He ordered a lumbar MRI scan to rule out left-side L4-5 herniated nucleus pulposus, and advised that appellant was unable to return to work until further notice.

A December 29, 2011 lumbar MRI scan revealed developmental narrowing of the central canal at L3-4 through L5-S1 without evidence of nerve root compromise. There was also evidence of mild dorsal epidural lipomatosis.

In a January 6, 2012 follow-up report, Dr. Harrer noted that appellant complained of penis numbness and voiding on himself after completing urination. Appellant was concerned he had neurologic issues. On physical examination, he continued to complain of extreme pain. Appellant was noted to have been ambulating with a cane. Dr. Harrer also noted that the recent lumbar MRI scan showed minimal congenital stenosis. There were no herniated discs or other issues of an acute nature. Dr. Harrer indicated appellant's problems were no longer orthopedic,

[9] Sarah A. Foster-Chang, a nurse practitioner, examined appellant earlier that day. Her initial clinical impression was possible patellar subluxation and/or joint effusion. Ms. Foster-Chang excused appellant from work and advised against any weight bearing for two days. Appellant was to remain off duty until December 26, 2011.

but maybe a neurologic dysfunction. As such, he referred appellant for a complete neurologic examination. Appellant was to remain off work until seen by a neurologist.

Dr. Leila Hardware, a Board-certified family practitioner, examined appellant on January 9, 2012. She noted that he was maneuvering a manual patient bed at work on December 21, 2011 when his left knee gave out. Since then, appellant had been experiencing severe pain in the left knee, left lower extremity, and lower back. The pain was aggravated by walking and sitting/standing for short periods of time. Also, appellant's pain made it uncomfortable to sleep. Dr. Hardware further noted that he had been experiencing numbness, tingling, and loss of sensation of his left lower extremity and penis. She stated that appellant essentially had neuropathy as a result of his work-related injury. Dr. Hardware also noted the results of his lumbar and left knee MRI scans. She indicated that in light of appellant's neuropathic symptoms, he required further evaluation and treatment with a neurologist as soon as possible. Follow-up treatment notes from January 23, 2012 included diagnoses of left lower extremity radiculopathy/paresthesia, patellar tendinitis, chondromalacia, lumbar stenosis, and urinary incontinence.

Dr. Edward J. Gallagher, a Board-certified physiatrist, examined appellant on February 1, 2012 and administered an electromyography (EMG). He noted that appellant was employed as a registered nurse and while at work on December 21, 2011, he was pumping up a stretcher with his left lower extremity and fairly acutely developed knee pain. Later that same day, appellant was seen by an occupational medicine nurse who manipulated his left knee, which resulted in the worse pain of his life. He also reported having developed pain in the left buttock on December 21, 2011, which spread to his left heel. Dr. Gallagher noted that appellant had not been able to work since the December 21, 2011 incident. He further noted that appellant currently had paresthesias, particularly in the lateral toes on the left, but also to an extent in the ball of the foot, and also some paresthesias in the right toes. Dr. Gallagher indicated that walking increased appellant's symptoms in the left lower extremity. However, appellant was able to ambulate independently without an assistive device. Dr. Gallagher also noted that appellant had seen an orthopedic surgeon, but had not yet undergone physical therapy. Appellant was currently being maintained on various pain medications. Most days his pain was a 6-7/10. Dr. Gallagher also noted that appellant's left knee and lumbar MRI scans were essentially unremarkable. He described appellant as mildly overweight, but an otherwise healthy appearing male in mild discomfort. Examination of the left knee revealed good range of motion and no effusion. Tinel's sign was negative over the bilateral tarsal tunnels and straight leg raising test was weakly positive on the left. Deep tendon reflexes were trace at both knees, trace at the right ankle, and absent at the left ankle.

Dr. Gallagher noted that appellant's EMG was not consistent with polyneuropathy or tarsal tunnel syndrome. There was also no evidence of radiculopathy in the right lower extremity. However, Dr. Gallagher noted the EMG had suggested, but was not diagnostic evidence of left L5 and/or S1 radiculopathy. He commented that despite the unimpressive nature of the observed abnormalities, they were acute and probably clinically significant to appellant's pain, which radiated from his back ending up as paresthesias in the toes. Dr. Gallagher's overall diagnostic impression was "[p]robable acute left L5 and/or S1 radiculopathy." He recommended conservative treatment involving either physical therapy or referral for pain management injections.

Dr. Dahlia J. Irby, a neurologist, examined appellant on February 2, 2012 and reviewed his December 29, 2011 lumbar MRI scan and recent EMG results. Appellant reported having injured himself at work on December 21, 2011. His chief complaints included lower back pain, left leg pain, foot pain, numbness, tingling, and decreased penis sensation. Dr. Irby noted appellant had been diagnosed with patellar tendinitis. She also noted that his lumbar MRI scan showed developmental narrowing of the central canal at L3-4 through L5-S1 without evidence of nerve root compromise, as well as mild dorsal epidural lipomatosis. Additionally, Dr. Irby noted Dr. Gallagher's diagnostic impression of probable acute left L5 and/or S1 radiculopathy. She concluded that appellant had signs and symptoms of left S1 radiculopathy. Although there was no significant impingement on the left at his L5-S1 nerve root region, Dr. Irby found that he exhibited signs and symptoms of the condition. She recommended physical therapy.

In a report dated February 3, 2012, Dr. Latimore-Collier described appellant's treatment and various diagnostic studies administered since December 21, 2011. She indicated that the December 21, 2011 employment incident not only caused damage to his left knee, but also compressed his S1 nerve root resulting in lower back pain radiating down the left leg into his foot. Dr. Latimore-Collier explained that appellant was manually pumping a bed and because of his standing position, his left foot, knee, spine, and shoulders were unaligned and he was unprepared for the pain or pressure that he exerted on his knee and spine. She further explained that the unexpected pain and pressure caused damage to his left knee and compression to the S1 nerve, resulting in radicular pain from his lower back down his left leg to his foot.

On February 22, 2012 Dr. Hardware excused appellant from work until March 23, 2012. She explained that he had been diagnosed with left S1 radiculopathy, which caused back pain and paresthesia. Dr. Hardware also noted that appellant would be undergoing physical therapy for the next four weeks. Her February 22, 2012 treatment notes also reflected a diagnosis of left patellar tendinitis/chondromalacia.

When appellant returned on March 22, 2012, Dr. Hardware diagnosed S1 radiculopathy, lower back pain, obesity, patellar tendinitis, anxiety, stress, lower back paresthesia, and left leg paresthesia. She recommended a functional capacity evaluation, continued physical therapy, and advised appellant to follow up with an orthopedist and/or neurologist regarding his left leg pain. Dr. Hardware indicated that he could return to work in two months, May 23, 2012.

Dr. Hardware provided additional reports dated April 6 and August 30, 2012. Both reports summarized the treatment she provided appellant beginning January 9, 2012. Dr. Hardware noted that he initially presented with lower back pain radiating to his left lower extremity, burning, and numbness, gait dysfunction, difficulty sleeping, left knee pain, paresthesia in foot and toes, and urinary incontinence. Walking aggravated appellant's complaints and caused significant pain. Dr. Hardware stated that his complaints were all secondary to a December 21, 2011 work-related injury. At the time, she had referred appellant to a neurologist and recommended he follow up with an orthopedist. When appellant returned on January 23, 2012, his symptoms were unchanged, but his pain was reduced with medications. Dr. Hardware also noted that he returned to work on February 21, 2012, but continued to experience left lower extremity pain with numbness. During a March 22, 2012 follow up, she reported that appellant had better pain control and improvement with urinary issues, but minimal relief with respect to his left lower left extremity complaints. Despite a reduction in pain,

Dr. Hardware observed his inability to sit or stand for prolonged periods without having to change positions. She indicated that she saw appellant on two more occasions; April 12 and May 17, 2012. Dr. Hardware noted that by May 17, 2012 his symptoms improved, and he was cleared to return to work on May 23, 2012.

On appeal, counsel argues that appellant suffered a low back injury on December 21, 2011, and continues to suffer from the residuals of the work injury. In his May 29, 2014 brief, counsel noted that the claims examiner found Dr. Latimore-Collier's opinion irrelevant because of her personal relationship with appellant. Counsel also argued that the hearing representative failed to discuss in any detail the reports of Dr. Latimore-Collier.

LEGAL PRECEDENT ISSUE 1

A claimant seeking benefits under FECA has the burden of establishing the essential elements of his or her claim by the weight of the reliable, probative, and substantial evidence, including that an injury was sustained in the performance of duty as alleged and that any specific condition or disability claimed is causally related to the employment injury.[10]

ANALYSIS -- ISSUE 1

OWCP has only accepted left knee mild patellar tendinitis as employment related. Appellant claims to have also injured his lower back as a result of the December 21, 2011 employment incident. Where an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he bears the burden of proof to establish that the condition is causally related to the employment injury.[11]

Dr. Harrer, an orthopedic surgeon, examined appellant on December 28, 2011. At the time, appellant reported left knee pain and left lower back pain radiating down his left buttock into the left side of his knee. Dr. Harrer's initial impression was probable left lower back issue, creating left leg radiculopathy with minimal patella tendinitis of the left knee. He explained that it all started when appellant was at work manually pumping up a bed with a patient in it. Dr. Harrer ordered a lumbar MRI scan to rule out left-side L4-5 herniated nucleus pulposus. After obtaining an MRI scan on December 29, 2011, appellant returned to him for follow up on January 6, 2012. He continued to complain of extreme pain and was noted to be ambulating with a cane. Dr. Harrer noted that appellant's recent lumbar MRI scan showed minimal congenital stenosis, but no herniated discs or other issues of an acute nature. He determined that the problems were not orthopedic. Because of the possibility of neurologic dysfunction, Dr. Harrer referred appellant for a complete neurologic examination.

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[10] 20 C.F.R. § 10.115(e), (f); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996).

[11] *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004). Causal relationship is a medical question, which generally requires rationalized medical opinion evidence to resolve the issue. *See Robert G. Morris*, 48 ECAB 238 (1996). A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factors must be based on a complete factual and medical background. *Victor J. Woodhams*, 41 ECAB 345, 352 (1989). 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 factors. *Id.*

Although he ruled out an orthopedic condition, Dr. Harrer did not provide a definitive diagnosis. Also, apart from noting a temporal relationship, he did not explain how the lower back and left lower extremity complaints were causally related to the above-described employment incident. A physician's opinion on causal relationship must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factors.[12]

Dr. Gallagher examined appellant on February 1, 2012 and administered an EMG. He noted that on December 21, 2011 appellant was at work pumping up a stretcher with his left lower extremity when he fairly acutely developed knee pain. Also that same day, appellant reported developing pain in the left buttock, which spread to his left heel. Based on his evaluation, Dr. Gallagher's diagnostic impression was probable acute left L5 and/or S1 radiculopathy. Other than noting the reported December 21, 2011 onset of left buttock and left heel pain, he did not specifically address the etiology of appellant's radiculopathy.

Dr. Irby, who examined appellant on February 2, 2012, noted "[appellant] stated that he injured himself at work on [December 21, 2011]." However, her report did not include a description of the December 21, 2011 employment incident. Also, Dr. Irby did not specifically attribute appellant's "signs and symptoms of left S1 radiculopathy" to his employment injury.

Dr. Vitanzo saw appellant on February 16, March 15, and April 5, 2012. He diagnosed left patellar tendinitis. By April 5, 2012, appellant reached maximum medical improvement, and Dr. Vitanzo did not think any additional treatment was warranted for his knee. Dr. Vitanzo released appellant to return to work at that time. Although Dr. Vitanzo was aware of appellant's back complaints and left-side radicular symptoms, he did not offer an opinion regarding the cause of appellant's lumbar condition. Additionally, Dr. Vitanzo deferred to appellant's other health care providers regarding any lumbar-related work limitations. Because his treatment was limited to appellant's left knee condition, his various reports do not establish an employment-related lumbar condition.

In her April 6 and August 30, 2012 reports, Dr. Hardware stated that appellant's complaints were all secondary to a December 21, 2011 work-related injury. When she initially examined appellant on January 9, 2012, she noted that he was maneuvering a manual patient bed at work on December 21, 2011 when his left knee gave out. This is not entirely consistent with appellant's description of the December 21, 2011 employment incident. The February 21, 2011 Form CA-1 indicates that he was "trying to manually raise a bed containing a patient by using a foot pedal" when the bone in his left knee popped out of place. In addition to an incomplete history of injury, Dr. Hardware never fully explained how appellant's complaints were secondary to a work-related injury on December 21, 2011. A physician's opinion on causal relationship must be based on a complete factual and medical background and must be supported by medical rationale.[13]

[12] *Victor J. Woodhams, id*.

[13] *Id.*

Dr. Latimore-Collier, appellant's spouse, addressed causal relationship in her February 3, 2012 report. After describing appellant's treatment, including the various diagnostic studies administered since December 21, 2011, she indicated the accepted employment incident not only damaged the left knee, but also compressed appellant's S1 nerve root resulting in lower back pain radiating down the left leg into his foot. Dr. Latimore-Collier explained that appellant was manually pumping a bed and because of his standing position, appellant's left foot, knee, spine, and shoulders were unaligned and he was unprepared for the pain or pressure that he exerted on his knee and spine.

Counsel noted that the claims examiner found Dr. Latimore-Collier's opinion irrelevant because she was appellant's wife. Although he is correct regarding the claims examiner's assessment, the hearing representative did not similarly dismiss Dr. Latimore-Collier's opinion based on a perceived conflict of interest. Instead, she found that Dr. Latimore-Collier's February 3, 2012 report lacked probative value because she did not provide a specific diagnosis for appellant's back symptoms and because she failed to explain her opinion regarding S1 nerve compression in light of contrary diagnostic evidence.

In her February 3, 2012 report, Dr. Latimore-Collier noted that appellant had been referred for a lumbar MRI scan, but she did not specifically comment on the results of the December 29, 2011 MRI scan. The study revealed mild dorsal epidural lipomatosis and developmental narrowing of the central canal at L3-4 through L5-S1, without evidence of nerve root compromise. Also, Dr. Latimore-Collier's report indicated that appellant's EMG "noted S1 radiculopathy." Her characterization of the results is not entirely accurate. Dr. Gallagher, who administered the February 1, 2012 EMG, and Dr. Irby, the neurologist who reviewed the study, did not find definitive evidence of S1 radiculopathy. Dr. Gallagher noted that the study was "suggestive," but not complete diagnostic evidence supporting left L5 and/or S1 radiculopathy. He characterized both the lumbar MRI scan and lower extremity EMG results as "unimpressive." Also, Dr. Irby noted that there was "no significant impingement on the left at [appellant's] L5-S1 nerve root region."

Dr. Latimore-Collier's February 3, 2012 finding of employment-related S1 nerve root compression does not adequately address the underlying diagnostic studies, which at least one physician characterized as "unimpressive." As noted, a physician's opinion on causal relationship must be based on a complete factual and medical background and must be supported by medical rationale.[14]

Based on the above-noted medical evidence, OWCP properly found that appellant did not establish a causal relationship between his claimed lumbar condition and the December 21, 2011 employment incident. Accordingly, the decision of OWCP denying his alleged lumbar condition is affirmed.

[14] *Id.*

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(a) and 20 C.F.R. §§ 10.605 through 10.607.

LEGAL PRECEDENT -- ISSUE 2

Once OWCP accepts a claim and pays compensation, it bears the burden to justify modification or termination of benefits.[15] Having determined that an employee has a disability causally related to his or her federal employment, OWCP may not terminate compensation without establishing either that the disability has ceased or that it is no longer related to the employment.[16] After termination or modification of compensation benefits, clearly warranted on the basis of the evidence, the burden for reinstating compensation shifts to the employee.[17]

The right to medical benefits for an accepted condition is not limited to the period of entitlement to compensation for disability.[18] To terminate authorization for medical treatment, OWCP must establish that the employee no longer has residuals of an employment-related condition that require further medical treatment.[19]

ANALYSIS -- ISSUE 2

Neither appellant nor counsel specifically challenges OWCP's finding with respect to entitlement to compensation and medical benefits regarding the accepted left knee condition. When Dr. Vitanzo last examined appellant, he released him to return to full duty effective April 5, 2012. Appellant's left knee was noted to be "doing fine," with good range of motion, no significant pain over the patellar tendon, and a relatively normal gait. Dr. Vitanzo advised that appellant reached maximum medical improvement, and he did not believe additional treatment for the left knee was warranted. The Board finds that OWCP properly relied on Dr. Vitanzo's April 5, 2012 opinion as a basis for terminating compensation and medical benefits with respect to appellant's accepted left knee condition.

CONCLUSION

Appellant failed to establish that his claimed lumbar condition is causally related to his December 21, 2011 employment injury. The Board further finds that OWCP met its burden in terminating compensation and medical benefits effective May 16, 2012.

[15] *Curtis Hall*, 45 ECAB 316 (1994).

[16] *Jason C. Armstrong*, 40 ECAB 907 (1989).

[17] *I.J.*, 59 ECAB 408, 415 (2008). To prevail, the employee must establish by the weight of the reliable, probative and substantial evidence that he had an employment-related disability that continued after termination of compensation. *Id.*

[18] *Furman G. Peake*, 41 ECAB 361, 364 (1990); *Thomas Olivarez, Jr.*, 32 ECAB 1019 (1981).

[19] *Calvin S. Mays*, 39 ECAB 993 (1988).

ORDER

IT IS HEREBY ORDERED THAT the March 20, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 11, 2015
Washington, DC

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

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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