United States Department of Labor
Employees' Compensation Appeals Board

D.M., Appellant	)	
and	)	**Docket No. 16-1559**
	)	**Issued: January 25, 2017**
DEPARTMENT OF VETERANS AFFAIRS, BATTLE CREEK VETERANS ADMINISTRATION MEDICAL CENTER, Battle Creek, MI, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 27, 2016 appellant filed a timely appeal from a March 28, 2016 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 merit decision in the case.

ISSUE

The issue is whether appellant has met his burden of proof to establish that his claimed conditions are causally related to factors of his federal employment.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On August 15, 2014 appellant, then a 45-year-old information technology specialist, filed an occupational disease claim (Form CA-2) alleging that he developed a bulging lumbar disc as a result of repetitively carrying a variety of equipment up and down stairs while working. He first became aware of his condition on November 1, 2013 and realized it was causally related to his federal employment on the same date. Appellant did not stop work.

In an undated statement, appellant reported that on May 8, 2008 he was carrying a heavy piece of equipment weighing 60 pounds from his office to a storage area when the item slipped out of his control and he heard a loud popping sound coming from his back. He sought treatment for these injuries and continues to be treated for the same injury. Appellant noted having severe back pain flare ups.

Appellant underwent physical therapy on June 2 and 11, 2008. He was treated by Dr. Sita Kondapaneni, a Board-certified physiatrist, on December 5, 2008, for low back and right knee pain. Appellant reported injuring his back in May 2008 while carrying a heavy piece of equipment down stairs. Dr. Kondapaneni diagnosed low back pain, degenerative disc disease, possible radiculopathy, right knee arthralgia, status post anterior cruciate ligament repair, and multiple arthroscopic surgeries. On February 1, 2012 appellant was treated by a physician assistant who diagnosed chronic low back with acute exacerbation.

Appellant submitted reports from Dr. Ireneo Diaz, Jr., a Board-certified internist. On February 6, 2012 Dr. Diaz diagnosed chronic low back pain with acute exacerbation and muscle spasm. On September 8, 2014 he noted that appellant sustained a back injury at work in May 2008 when carrying a heavy piece of equipment down stairs. Appellant related having dull, constant pain over the lower back and hips. His low back pain and exacerbations were managed by physical therapy and pain medication. Dr. Diaz advised that an April 1, 2014 magnetic resonance imaging (MRI) scan revealed facet degeneration at L1-2 and L2-3, L3-4, a broad-based disc bulge at L4-5, and L5-S1 disc desiccation. He opined that the findings could account for appellant's current symptoms. Dr. Diaz indicated that exacerbations of pain limited activities of daily living as well as work. On September 14, 2012 he treated appellant for low back pain.

On October 30, 2013 and February 27, 2014, appellant was treated by Dr. Dean Shoucair, an osteopath, for backache, myalgia, and status post arthroscopic surgery of the right knee for anterior cruciate ligament repair in 1991. Dr. Shoucair diagnosed chronic low back, hips and bilateral knee pain, and myalgia.

Appellant was treated by Dr. Salena Cox-Johnson, a Board-certified family practitioner, on June 23, 2014 for a history of chronic back pain, bilateral hip pain, neuropathy and right knee anterior cruciate ligament pain. Dr. Cox-Johnson diagnosed chronic pain with no improvement with current therapy. Appellant submitted a September 4, 2014 certification of health care provider from Natasha Brown, a nurse practitioner, who noted diagnoses and advised that appellant was dependent on methadone for chronic low back pain caused by a 2008 injury.

By letter dated October 1, 2014, OWCP advised that the evidence was not sufficient to establish that the claimed work factors occurred as alleged to have caused the injury. It also

noted that there was no physician's opinion describing the relationship between how the work activities caused or aggravated a medical condition. OWCP provided a questionnaire and asked that appellant specifically describe the employment-related activities that contributed to his condition, how often he performed the activities, and report any activities outside his employment. It also requested that the employing establishment provide comments from a knowledgeable supervisor. Appellant did not respond within the 30 days allotted.

In a decision dated November 5, 2014, OWCP denied appellant's claim finding that the evidence of record was insufficient to establish the claimed work factors.

On July 31, 2015 appellant requested reconsideration. In a July 17, 2015 statement, he noted that his job duties included regularly lifting and carrying a wide range of equipment weighing between 40 and 80 pounds up and down stairs and between buildings. Appellant's duties also involved installing and accessing equipment including 50- to 80-pound batteries in cramped or areas difficult to access such as attics and closets.

Appellant submitted a report from Dr. Diaz dated December 15, 2014 who treated appellant from 2009 to 2012 for a back injury sustained at work in May 2008. He reported that his duties required carrying equipment up and down stairs, climbing ladders, lifting equipment weighing between 40 to 80 pounds, and crawling under desks to connect cables. Dr. Diaz opined "that the position description of [appellant's] job, the repetitious movements aggravated" appellant's back condition. He noted that appellant was prescribed physical therapy and pain medication, but continued to have an acute exacerbation of his low back pain.

Appellant began treatment with Dr. Tejpaul Pannu, a Board-certified neurosurgeon, on January 22, 2015. In a report of that date, Dr. Pannu noted that appellant related having back pain beginning 2008 after a work injury when he was carrying equipment down stairs. He diagnosed lumbar radiculopathy and recommended a lumbar fusion. In a January 22, 2015 operative report, Dr. Pannu performed an arthrodesis, posterior interbody technique at L5-S1 with complete discectomy and placement of titanium cage, instrumentation at L5-S1, and posterolateral arthrodesis at L5-S1. He diagnosed lumbar radiculopathy at S1, intractable low back pain, and left-sided S1 radiculopathy.

Appellant was hospitalized again on May 5, 2015 for lumbar radiculopathy. Dr. Pannu noted an x-ray revealed a slight migration of the posterior cage. He diagnosed lumbar radiculopathy and status post lumbar fusion and recommended surgery to correct the migration. On May 5, 2015 Dr. Pannu performed an anterior lumbar interbody fusion at L5-S1 and diagnosed lumbar spondylolisthesis and sciatica.

In a June 4, 2015 narrative report, Dr. Pannu noted treating appellant since December 2014 for back pain, which began in 2008 after a work-related injury when carrying equipment down stairs. He noted a discogram and lumbar spine MRI scan were positive for herniation at L5-S1. Dr. Pannu advised that based on the imaging results, physical evaluation, and lack of improvement with conservative treatment he recommended an L5-S1 posterior lumbar interbody fusion for lumbar radiculopathy, which was performed on January 22, 2015. Appellant did well postoperatively, but an April 6, 2015 x-ray revealed that his cage had migrated two millimeters into his spinal cord. Dr. Pannu recommended correcting the cage

migration and on May 5, 2015 he performed an L5-S1 anterior lumbar interbody fusion. He opined that the position description of appellant's job including repetitive movements and weight he was required to carry likely aggravated his pain symptoms in addition to going so long without treatment. Dr. Pannu noted that appellant was disabled and he did not anticipate that appellant would reach maximum medical improvement for a year.

In a December 21, 2015 addendum report, Dr. Pannu opined that "without a doubt" appellant's job aggravated his lumbar radiculopathy. This involved "the required weight [appellant] must carry and the repetitive movements he must perform … in addition to going so long without proper treatment" ultimately resulted in appellant's need for lumbar spine surgery.

In a letter dated February 26, 2016, OWCP requested that Dr. Pannu review a statement of accepted facts and provide a reasoned medical opinion as to whether appellant's job activities aggravated the diagnosed condition of lumbar radiculopathy. It also requested that Dr. Pannu address whether a nonwork-related incident in which appellant vacuumed out his car contributed to the worsening of his condition and the need for surgery.

In a decision dated March 28, 2016, OWCP modified the November 5, 2014 denial of appellant's claim. It found that he established that the claimed work factors occurred as alleged, but that his claim was denied because the medical evidence failed to establish that the diagnosed condition was causally related to the accepted incident or event.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim. When an employee claims that he or she sustained an injury in the performance of duty, he or she must submit sufficient evidence to establish that he or she experienced a specific event, incident or exposure occurring at the time, place, and in the manner alleged. Appellant must also establish that such event, incident, or exposure caused an injury.[2]

Whether an employee actually sustained an injury in the performance of duty begins with an analysis of whether fact of injury has been established.[3] To establish fact of injury in an occupational disease claim, 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.[4]

[2] *See Walter D. Morehead*, 31 ECAB 188, 194 (1979) (occupational disease or illness); *Max Haber*, 19 ECAB 243, 247 (1967) (traumatic injury). *See generally John J. Carlone*, 41 ECAB 354 (1989); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[3] *S.P.*, 59 ECAB 184, 188 (2007).

[4] *R.R.*, Docket No. 08-2010 (issued April 3, 2009); *Roy L. Humphrey*, 57 ECAB 238, 241 (2005).

The medical evidence required to establish causal relationship is generally rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[5]

ANALYSIS

OWCP accepted that from 2008 to 2014 appellant's duties as an information technology specialist involved regularly lifting and carrying a wide range of equipment up and down stairs and installing and accessing equipment in cramped or difficult to access areas. However, the Board finds that the medical evidence of record is insufficient to establish that these work activities caused or aggravated his diagnosed lumbar conditions.

Appellant submitted reports from Dr. Pannu who treated him for progressive back pain. Dr. Pannu performed an anterior lumbar interbody fusion at L5-S1 on January 22, 2015 and an anterior lumbar interbody fusion at L5-S1 on May 5, 2015 and diagnosed lumbar radiculopathy at S1, lumbar spondylolisthesis, and sciatica. In a report dated June 4, 2015, he opined that appellant's job including repetitive movements and weight he was required to carry likely aggravated his pain and symptoms. In an addendum report dated December 21, 2015, Dr. Pannu opined that "without a doubt" appellant's job aggravated his lumbar radiculopathy, which included carrying heavy items and performing repetitive movements resulted in his need for lumbar spine surgery. The Board finds that, although Dr. Pannu supported causal relationship, noting that appellant's job required carrying heavy items and repetitive movements, he did not provide medical rationale explaining the basis of his conclusory opinion regarding the causal relationship between appellant's lumbar radiculopathy and need for surgery and the factors of employment.[6] Dr. Pannu did not explain the process by which repetitive movements and repetitive carrying would have caused or aggravated a diagnosed condition. Therefore, these reports are insufficient to meet appellant's burden of proof.

On September 8, 2014 Dr. Diaz noted that appellant sustained a back injury at work in May 2008 when carrying a heavy piece of equipment down stairs. He opined that the findings could account for appellant's current symptoms. Similarly, in a December 15, 2014 report, Dr. Diaz opined that appellant's work duties and repetitious movements aggravated his back condition. The Board finds that, although Dr. Diaz supported causal relationship, he did not provide medical rationale explaining the basis of his opinion regarding the causal relationship

[5] *Solomon Polen*, 51 ECAB 341 (2000).

[6] *See T.M.*, Docket No. 08-0975 (issued February 6, 2009) (a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale).

between appellant's lumbar condition and work factors.[7] Therefore, this report is insufficient to meet appellant's burden of proof.

Appellant was treated by Dr. Kondapaneni on December 5, 2008, for low back and right knee pain. He reported injuring his back in May 2008 while carrying a heavy piece of equipment down stairs. Dr. Kondapaneni's diagnoses included low back pain, degenerative disc disease, and possible radiculopathy. However, this report is insufficient to establish the claim as she did not specifically address whether appellant's work activities caused or aggravated a diagnosed medical condition.[8]

Likewise, the other medical reports from Dr. Shoucair and Dr. Cox-Johnson are insufficient to establish the claim as they do not specifically address whether appellant's employment activities caused or aggravated his diagnosed medical condition.[9] Therefore, these reports are insufficient to meet his burden of proof.

Appellant also submitted evidence from a nurse practitioner, a physician assistant, and a physical therapist. However, the Board has held that reports of nurse practitioners, physician assistants, and physical therapists are not probative medical evidence these practitioners are not considered physicians under FECA.[10] Thus, these records are of no probative medical value in establishing appellant's claim.

The remainder of the medical evidence, including reports of diagnostic testing, are of limited probative value as they fail to provide an opinion on the causal relationship between appellant's employment factors and his diagnosed lumbar condition. For this reason, this evidence is not sufficient to meet his burden of proof.[11]

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.

[7] *Id.*

[8] *A.D.*, 58 ECAB 149 (2006) (medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

[9] *Id.*

[10] *See David P. Sawchuk*, 57 ECAB 316 (2006) (lay individuals such as physician's assistants, nurses and physical therapists are not competent to render a medical opinion under FECA); *Sean O'Connell*, 56 ECAB 195 (2004) (reports of nurse practitioners and physician assistants are not probative medical evidence as these persons are not considered physicians under FECA). 5 U.S.C. § 8101(2) (this subsection defines a "physician" as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law).

[11] *Supra* note 8.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that his claimed conditions were causally related to factors of his federal employment.

ORDER

IT IS HEREBY ORDERED THAT the March 28, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 25, 2017
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board