# United States Department of Labor
# Employees' Compensation Appeals Board

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| **WAYNE J. DEDMOND, Appellant** | ) | |
| **and** | ) | **Docket No. 04-794** |
| | ) | **Issued: June 16, 2004** |
| **DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Jackson, MS, Employer** | ) | |

*Appearances:*
*Wayne J. Dedmond, pro se*
*Office of Solicitor,* for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member
MICHAEL E. GROOM, Alternate Member

### ***JURISDICTION***

On February 6, 2004 appellant filed a timely appeal from a decision of the Office of Workers' Compensation Programs' dated January 8, 2004, which denied modification of a December 27, 2002 decision denying his claim. Pursuant to 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 sustained spinal cord disc damage, discs, bulges and cervical bone spurs, causally related to his federal employment duties.

### ***FACTUAL HISTORY***

On July 11, 2002 appellant, then a 52-year-old medical clerk, filed a notice of occupational disease, claiming that on May 1, 2002 he became aware that he had developed spinal damage, which he attributed to his work duties, including repetitive typing, bending,

prolonged sitting and lifting of medical records. His supervisor indicated that he was last exposed to the conditions alleged to have caused his condition on July 24, 2002.

By letter dated August 6, 2002, the Office advised appellant that the information submitted was insufficient to establish his claim. It requested further information about the implicated employment activities, the frequency of occurrence, similar conditions and outside activities. The Office also requested a rationalized medical support discussing the causal relationship between the employment factors implicated and his medical conditions.

On October 3 and December 5, 1997 appellant was treated by Dr. Ami Patel, a Board-certified nephrologist, for benign essential hypertension and chronic glomerulonephritis with an unspecified pathological lesion in his kidney. On August 23, 2001 he was treated by Dr. Olawale Fashina for benign hypertensive renal disease without renal failure. On November 28, 2001 appellant had an allergy/adverse reaction to an unknown drug and was seen by Dr. Fashina.

On April 18, 2002 appellant was seen at the orthopedic clinic complaining of right shoulder pain for six to eight months, aggravated with abduction and forward flexion, but with excellent range of motion and some slight subacromial tenderness. X-rays showed some sclerosis of the greater tuberosity, a fairly good subacromial space and minimal degenerative changes in the acromioclavicular joint. Conditions were noted as some mild impingement and tendinitis of the right shoulder and left arm pain that radiated down the posterolateral forearm and into the fingers, more of a C6 dermatome and pain with lateral deviation and extension of the neck with a positive Spurling test. Dr. Neal C. Chapel, an orthopedist, opined: "He operates a computer all day and there may be an element of outlet syndrome as well." Dr. Chapel listed to rule out cervical radiculopathy, cervical outlet, right impingement and rotator cuff tendinitis.

Cervical spine x-rays obtained on May 1, 2002 by Dr. Eli B. Park, a radiologist, were reported as showing a "significant anterior spur and degenerative changes as well as disc space narrowing between C5-6 with mild kyphotic curvature at the same level. Atlanto-axial relationship, grossly appear[s] normal so as prevertebral soft tissue. Bones are markedly demineralized."

A cervical magnetic resonance imaging (MRI) scan obtained by Dr. Venugopal D. Turu, a radiologist, showed moderate bulging of the disc material at C5-6 and C6-7 interspaces. Mild bulging of the disc material was also noted at C3-4 and C4-5 interspaces. The spinal canal and neural foramina were unremarkable at the C2-3 interspace. Mild central bulging of the disc material was noted at C3-4 interspace which was seen causing minimal pressure effect on the thecal sac. The spinal canal and neural foramina at C3-4 interspace appeared unremarkable. Mild central bulging of the disc material was also noted at C4-5 interspace which was seen causing minimal pressure effect on the thecal sac. The spinal canal and neural foramina at C4-5 interspace appeared unremarkable. Bulging of the disc material was also noted at C5-6 interspace which was seen causing moderate pressure effect on the thecal sac. The spinal canal at C5-6 interspace appeared somewhat narrower. Both neural foramina at C5-6 interspace appeared unremarkable. Bulging of the disc material was noted at C6-7 interspace. Abnormal signal anterior to the thecal sac at C6-7 interspace could represent a mild degree of central

herniation of the disc material. This was seen causing minimal pressure effect on the thecal sac. The spinal canal and neural foramina at C6-7 interspace appeared unremarkable. The spinal canal and neural foramina at C7-T1 interspace appeared unremarkable.

On June 18, 2002 appellant was seen by Dr. Elliott B. Nipper, a surgical resident, at the orthopedic clinic for complaints of right shoulder pain which was aggravated by abduction, with complaints of tingling at night radiating down his left arm. Examination revealed right upper extremity pain with resistant abduction minimally along with external rotation, none with internal rotation and otherwise normal. Range of motion showed mild impingement, but was otherwise normal. A cervical MRI scan was noted to reveal a C6-7 disc herniation. Right rotator cuff tendinitis versus partial tear was diagnosed.

On June 27, 2002 Dr. Nipper noted that appellant complained of pain and tingling radiating down his arm. On July 3, 2002 appellant was seen by Dr. Fashina for gastroesophageal reflux disease (GERD), cervical disc problems with some numbness in his left arm, hypertension, poor erectile function and occasional palpitations. Appellant's medications were reviewed.

By decision dated December 27, 2002, the Office rejected appellant's claim, finding that the medical evidence submitted did not provide a discussion of the causal relationship of the conditions found to the implicated factors of his employment.

By letter dated December 5, 2003, appellant requested reconsideration of the December 27, 2002 decision. He claimed that the actual nature of his injury was not known until the MRI scan revealed disc disease. Appellant submitted computer records from January 1 to December 4, 2003, which listed conditions including cervicalgia, carpal tunnel syndrome, benign hypertensive renal disease without renal failure, benign essential hypertension and chronic glomerulonephritis with unspecified pathological lesion in the kidney. He was treated by Drs. Fashina and Patel and Dr. Narayana Swamy, a Board-certified internist specializing in cardiovascular diseases. Other problems were noted to include cervical degenerative joint disease, tenosynovitis, GERD and poor erectile function.

On February 20 and April 18, 2003 Dr. Fashina reviewed appellant's medications and recommended increasing the dose of fosinopril. A June 11, 2003 record entry noted appellant's diagnosis as de Quervain's disease of the right wrist of his right first dorsal compartment. Dr. Nawaiz Ahmad, an orthopedic resident, noted that her had a positive Finkelstein test and tenderness at the first dorsal compartment. A steroid injection was administered into the first dorsal compartment. On October 15, 2003 appellant was seen in the orthopedic hand clinic for de Quervain's tenosynovitis which had improved from July, but it was noted that he still wore his thumb Spica splint. Regarding his left wrist numbness, Dr. Jason Arnold Craft, a surgery resident, noted that it "could be due to his cervical spine, if carpal tunnel was very mild." Continued use of the night splint was recommended.

An October 10, 2003 neurosurgery clinic note indicated that appellant was seen a year prior for chronic neck pain and arm pain and numbness. He was found to have cervical disc disease most prominent at C5-6 and C6-7 with lateral recess narrowing. The record noted that in

recent weeks appellant felt that his left arm was going numb, especially worse at night with diffuse numbness spreading into the forearm and with neck discomfort. The record indicated that appellant also had right hand complaints supposedly due to tendinitis. Diagnosis was noted as cervical disc disease versus carpal tunnel syndrome. This note was signed by Dr. Swamy.

By decision dated January 8, 2004, the Office denied modification of the December 27, 2002 decision. The Office found that the medical evidence did not contain a rationalized medical opinion on the causal relationship of appellant's conditions to the implicated factors of his employment.

## ***LEGAL PRECEDENT***

An employee seeking benefits under the Federal Employees' Compensation Act[1] has the burden of establishing the essential elements of his claim, including the fact that he is an "employee of the United States" within the meaning of the Act, that the claim was timely filed within the applicable time-limitation period of the Act, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed is causally related to the employment injury.[2]

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

Medical opinions couched in speculative terms, such as the use of the words "probably," "most likely" or "could be" are not definite and, therefore, they are of diminished probative value.[4] Neither physical therapists nor occupational therapists are physicians as defined under the Act;

[1] 5 U.S.C. § 8101 *et seq.*

[2] *Gary J. Watling*, 52 ECAB 278 (2001); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

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

[4] *See Brian E. Flescher*, 40 ECAB 532 (1989).

their reports, therefore, do not constitute competent medical evidence to support a claim.[5] Nurses are also not considered to be physicians under the Act and, therefore, their reports have no probative value on the issue of causal relationship.[6]

## ***ANALYSIS***

Appellant has established that he is an employee of the United States and that his claim was timely filed. However, he has not established that he sustained an injury in the performance of duty as alleged, as none of the medical evidence contains a rationalized medical opinion from a physician explaining the causal relationship between any of the diagnosed conditions to the factors of his federal employment.

Dr. Patel addressed appellant's benign essential hypertension and chronic glomerulonephritis. His opinion, therefore, does not support his spinal damage claim. Dr. Fashina addressed appellant's benign hypertensive renal disease and, therefore, her report also did not support his spinal injury claim. She later noted GERD, cervical disc problems with some numbness in his left arm, hypertension and occasional palpitations, but failed to provide a rationalized medical opinion as to the causal relationship of these conditions to factors of appellant's employment. Dr. Fashina's notes do not constitute probative medical evidence in support of his claim.

Dr. Ahmad diagnosed de Quervain's tenosynovitis of the right first dorsal compartment and treated appellant with a steroid injection, but he did not provide an opinion on causal relationship and, therefore, his report is of diminished probative value and is insufficient to support his claim.[7]

Dr. Craft noted appellant's right de Quervain's tenosynovitis, but he provided a speculative opinion as to causal relationship, noting that it "could be due to his cervical spine, if carpal tunnel was very mild." As this opinion was couched in speculative terms, it is insufficient to establish appellant's claim.[8]

Dr. Chapel opined that appellant operated a computer all day and that, therefore, "there may be an element of outlet syndrome as well." As his opinion was couched in speculative terms, it is of diminished probative value and his diagnoses were provided in terms of "rule out" various conditions, including cervical radiculopathy, cervical outlet, right impingement and rotator cuff tendinitis. His opinions, therefore, were insufficient to establish appellant's claim as

[5] *See Jennifer L. Sharp*, 48 ECAB 209 (1996); *Thomas R. Horsfall*, 48 ECAB 180 (1996); *Barbara J. Williams*, 40 ECAB 649 (1988); *Theresa K. McKenna*, 30 ECAB 702 (1979).

[6] *Vicky L. Hannis*, 48 ECAB 538 (1997); *Joseph N. Fassi*, 42 ECAB 231 (1991); *Joseph P. Bennett*, 38 ECAB 484 (1987).

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

[8] *See Brian E. Flescher*, *supra* note 4.

they were speculative, exclusionary and lacked any rationalized medical opinion as to causal relationship with any of appellant's employment factors.[9]

Neither Dr. Park, nor Dr. Turu provided an opinion on the causal relationship of the conditions found on x-ray diagnostic testing. Therefore, their reports have no probative value in establishing causal relationship.[10]

Dr. Nipper did not address causal relationship with factors of appellant's employment in his orthopedic clinic medical note and the diagnosis given was speculative, as it was a right rotator cuff tendinitis versus partial tear. As he did not address causal relationship and was speculative about the diagnosis, his opinion is of reduced probative value.[11]

Much of the medical evidence submitted, was provided by other health care personnel. As noted above, the reports from nurses, physical therapists and occupational therapists do not constitute probative medical evidence.[12] Therefore, none of this additional evidence constitutes probative medical evidence in support of appellant's claim.

## ***CONCLUSION***

In this case, appellant alleged that he sustained several spinal conditions, including spinal cord damage, bulges in several discs and cervical bone spurs, causally related to his employment activities. However, he failed to submit probative medical evidence supporting this contention, such that he failed to meet his burden of proof to establish his claim.

[9] *Id.*

[10] *See Michael E. Smith, supra* note 7.

[11] *Id.*

[12] *Supra* note 5.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs' dated January 8, 2004 is affirmed.

Issued: June 16, 2004
Washington, DC

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member