

repetitive bending and lifting while performing filing and other activities. He noted beginning work for the employing establishment on June 5, 2000, stopping work on April 1, 2001 and being terminated on February 2, 2002.

In a December 17, 2002 report, Dr. Peter Wang, Jr., an orthopedic surgeon, noted that appellant's medical history was significant for a gunshot wound to the neck in 1991, which caused a central cord injury at the C4 level and left appellant with "significant disability" in both the upper and lower extremities. He explained that appellant sought administrative work at the employing establishment but his job required him to bend and lift files for several hours at a time. Dr. Wang found that appellant's back was stiff and painful with limited to nonexistent range of motion. He concluded that appellant's pain was likely a myofascial syndrome that would be chronic.

On May 30, 2002 appellant explained that he was hired as a veterans service representative, a position described as mostly sedentary and that the employing establishment was aware of his preexisting condition at the time he was retained. However, he stated that he was required to bend and stoop to lift heavy files and use his mostly contracted left hand to manipulate pages while scanning the files with a barcode reader on a weekly basis.

In an undated medical report, received into the record on April 4, 2003, Dr. Jonathan Cowen, an osteopath, reported that appellant was doing fairly well until he began his job with the employing establishment and was required to move files. He noted that appellant had seen multiple specialists, including a neurologist who had determined that appellant's pain was likely caused by "mechanical stresses." Dr. Cowen concluded: "[Appellant's] pain syndrome has escalated since the beginning of his filing duties. This very well may have caused or aggravated his now constant back pain."

On May 19, 2003 appellant explained that "walking, sitting, standing, bending and lifting even light things aggravates my constantly painful lower back and right leg." He stated that while he was in "constant pain from the neck down" due to his preexisting cervical injury, "the pain since [his] employment is different." Appellant characterized his low back pain as "more intense and debilitating," with radicular symptoms into the right leg. Also provided was a position description for the veterans service representative job, which stated: "The work normally involves mental rather than physical exertion. The work is mostly sedentary."

By decision dated June 3, 2003, the Office denied appellant's occupational disease claim. Appellant requested a hearing which took place on January 28, 2004.

By decision dated April 12, 2004, an Office hearing representative vacated the June 3, 2003 decision and remanded the case for further medical development.

In an April 5, 2004 report, Dr. Wang noted that a 2004 MRI scan revealed no significant disc herniation, foraminal or central canal stenosis, some disc bulging and some mild arthrosis. He reviewed appellant's medical history and noted that he had no pain before taking on the job and that the pain occurred after he started work. This suggested that appellant's pain was work related. Dr. Wang also concluded that appellant's cervical injury contributed to appellant's condition, as standing for prolonged periods of time, bending, stooping or reaching would put a

strain on the lumbar support musculature. Appellant would not be able to tolerate very well in comparison to someone who did not have a preexisting neurologic injury.

On May 7, 2004 the Office referred appellant, together with a statement of accepted facts to Dr. Steven Valentino, an osteopath, for a second opinion examination.

In a June 1, 2004 report, Dr. Valentino reviewed appellant's prior medical history and diagnostic reports from January 11, February 9 and August 22, 2001, which he found essentially normal. On physical examination, he noted that appellant walked with a shuffling gait, which was a residual of his spinal cord injury about the cervical spine. Dr. Valentino determined that appellant's cervical range of motion was moderately restricted without spasm, while appellant's thoracic and lumbar flexibility was complete, intact and painless. He diagnosed "status post cervical cord lesion, no evidence of low back injury" and concluded that appellant did not have a low back condition that was causally related to his federal employment. Dr. Valentino explained that appellant's diagnostic studies revealed only age-related degenerative changes about the lumbar spine. There was no evidence of any acute or traumatic finding. Any diagnosis of a myofascial condition would have resolved with conservative care over a short period of time. Dr. Valentino advised that residuals of the gunshot wound which involved the cervical spine were permanent, preexisting and not related to appellant's employment. In a work capacity report, he advised that appellant had "no limitations regarding low back symptoms" and could work a full eight-hour day.

In a June 16, 2004 decision, the Office denied appellant's claim.

On June 21, 2004 appellant requested a hearing. He submitted a December 19, 2000 electromyogram (EMG) report from Dr. Richard A. Buckler, a Board-certified neurologist, who diagnosed a mildly abnormal EMG. Dr. Buckler opined that appellant's right lower extremity pain may be due to mild lumbar radiculopathy or disc herniation. On March 7, 2005 Dr. Daniel L. Skubick, a Board-certified neurologist, noted widespread musculoskeletal dysfunction. He stated: "There is also an issue as to whether or not he has ongoing organic problems in his back. [Dr. Valentino] has considered him to be completely recovered with no underlying pathology of his lumbar spine, which is ludicrous, given the degree of activity that we have seen on two occasions." In a March 23, 2005 report, Dr. Cory Krueger, a Board-certified internist, stated that appellant complained of sharp shooting pains in his middle and low back and that he performed poorly on heel and toe walks, "indicating the disease in the L4 and S1 regions of his spine." Upon reviewing Dr. Cowen's report and appellant's history, Dr. Krueger opined "with reasonable medical certainty that appellant's current severe back pain and exacerbation of previous pain conditions were appreciated by the physical work required by his employer.

An oral hearing was held on March 30, 2005. After the hearing, appellant submitted reports from Dr. William E. Gusa, Jr., a Board-certified anesthesiologist, who noted performing branch blocks and joint injections in appellant's back in reports dated June 15, July 7 and 20, 2004. Dr. Gusa did not address the cause of appellant's back condition.

In an April 19, 2005 report, Dr. Skubick opined, based upon appellant's stated medical history, that there was a direct relationship between the physical demands of appellant's job and his musculoskeletal complaints. He diagnosed myofascial pain syndrome involving iliocostalis

and longissimus in the thoracolumbar region with secondary involvement of the right quadratus lumborum and the right gluteal complex. Dr. Skubick reiterated that appellant sustained a musculoskeletal injury to the paraspinal musculature/gluteal complex on the right as a direct result of his employment in 2000 and 2001.

In a decision dated June 2, 2005, the hearing representative affirmed the denial of appellant's occupational disease claim.

On July 13, 2005 appellant requested reconsideration. In a June 28, 2005 report, Dr. Skubick explained that myofascial pain syndrome was a recognized condition and he had identified the lumbar paraspinal musculature, the quadratus lumborum and the right gluteal complex as the affected muscles. He noted:

"I have linked this pathologically specific (myofascial trigger point) and anatomically specific diagnosis (the above listed muscles) to [appellant's] work at the [employing establishment]. It is impossible to offer a more specific diagnosis, either physiologically or anatomically, than I have offered. The diagnosis is incredibly specific and is not in any way a nonspecific musculoskeletal injury."

On March 24, 2004 Dr. Gusa diagnosed chronic low back pain with right radicular symptoms and noted that a lumbar MRI scan revealed mild lumbar degenerative changes. On April 6, 2004 he diagnosed low back and right lower extremity pain consistent with right sacroiliitis. Dr. Skubick also provided status notes as did Dr. Michael Kaye, a chiropractor, to whom he referred appellant.¹

In a November 15, 2005 report, Dr. Thomas E. Greene, a Board-certified orthopedic surgeon, noted appellant's medical history and "problems dating back to a work activity since the year 2000." He diagnosed persistent lumbar myofascial-type syndrome encompassing the lumbar paraspinal muscles, the quadratus lumborum, posterior gluteus and gluteus medius. Dr. Greene noted that appellant's x-rays appeared normal but that a physical examination revealed back stiffness and decreased range of motion. He concluded that appellant's onset of back discomfort was secondary to his work activity.

By decision dated July 7, 2006, the Office denied modification of its June 2, 2005 decision.

Appellant requested reconsideration on July 18, 2006.

In a March 21, 2006 report, Dr. Valentino noted examining appellant upon referral from Dr. Krueger. He diagnosed lumbar degenerative disc disease and residuals of cervical myelopathy. Dr. Valentino noted that appellant's facet and sacroiliac joints were normal but that his lumbar flexibility was mildly restricted. He opined that appellant's myelopathy affected his low back and leg complaints and recommended further diagnostic testing and consideration of a spinal cord stimulator or pain pump for treatment.

¹ Dr. Kaye did not report a diagnosis of spinal subluxation as demonstrated by x-ray.

In a March 31, 2006 report, Dr. Skubick remarked that Dr. Valentino previously found that appellant had nothing wrong but, when acting as a second opinion examiner had found muscles skeletal symptoms so significant as to recommend rather aggressive treatment. He also noted appellant's continuing lumbar pain and tenderness.

By decision dated October 26, 2006, the Office denied modification of the July 7, 2006 decision.

LEGAL PRECEDENT

An employee seeking benefits under the Federal Employees' Compensation Act² 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 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 disabilities and/or specific conditions for which compensation is claimed are causally related to the employment injury.³ 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.⁴

An occupational disease or injury is one caused by specified employment factors occurring over a longer period than a single shift or workday.⁵ The test for determining whether appellant sustained a compensable occupational disease or injury is three-pronged. To establish the factual elements of the claim, appellant must submit: "(1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying the factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the 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 factors identified by the claimant."⁶

An award of compensation may not be based on surmise, conjecture, speculation or upon appellant's own belief that there is a causal relationship between his or her claimed injury and his or her employment.⁷ To establish a causal relationship, appellant must submit a physician's report, in which the physician reviews the employment factors identified by appellant as causing his condition and, taking these factors into consideration as well as findings upon examination of

² 5 U.S.C. §§ 8101-8193.

³ *Elaine Pendleton*, 40 ECAB 1143 (1989).

⁴ *Victor J. Woodhams*, 41 ECAB 345 (1989).

⁵ *D.D.*, 57 ECAB ___ (Docket No. 06-1315, issued September 14, 2006).

⁶ *Michael R. Shaffer*, 55 ECAB 386, 389 (2004), citing *Lourdes Harris*, 45 ECAB 545 (1994); *Victor J. Woodhams*, *supra* note 4.

⁷ *Donald W. Long*, 41 ECAB 142 (1989).

appellant and his medical history, states whether the employment injury caused or aggravated appellant's diagnosed conditions and presents medical rationale in support of his or her opinion.⁸

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.⁹ The opinion of the physician must be based on a complete factual and medical background of the claimant¹⁰ and must be one of reasonable medical certainty¹¹ explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.¹²

ANALYSIS

Appellant alleged that he sustained chronic low back pain due to his employment duties from June 5, 2000 to April, 1, 2001 as a service representative. The Board finds that appellant has not submitted sufficient medical evidence to establish a causal relationship between his diagnosed conditions and his employment activities.

Appellant provided several medical reports supporting his claim. In a December 17, 2002 report, Dr. Wang noted appellant's preexisting cervical injury with significant disability in the upper and lower extremities. He addressed appellant's complaints of pain after performing filing duties for the employing establishment. Dr. Wang found no conclusive evidence of pain emanating from the spine and opined that it was likely due to a myofascial syndrome. On April 5, 2004 he noted being unable to make any findings concerning pathology. However, Dr. Wang attributed appellant's condition to his employment based on appellant's stated medical history and the fact that appellant had not reported similar symptoms before starting his federal employment. However, he did not present sufficient rationale supporting his conclusion. Dr. Wang did not explain why the particular work duties would cause or aggravate his lumbar condition. The Board has held that a medical opinion not fortified by medical rationale is of little probative value.¹³ Moreover, the mere fact that appellant's symptoms arose after starting employment, without more, is not probative. The Board has held that the concurrence of symptom development with a period of employment is insufficient to establish causal relationship.¹⁴ Dr. Cowen's April 4, 2003 report similarly did not establish causal relationship, as the physician presented insufficient rationale explaining how work activities caused or

⁸ *Id.*

⁹ *Conard Hightower*, 54 ECAB 796 (2003); *Leslie C. Moore*, 52 ECAB 132 (2000).

¹⁰ *Tomas Martinez*, 54 ECAB 623 (2003); *Gary J. Watling*, 52 ECAB 278 (2001).

¹¹ *John W. Montoya*, 54 ECAB 306 (2003).

¹² *Judy C. Rogers*, 54 ECAB 693 (2003).

¹³ *Caroline Thomas*, 51 ECAB 451, 456 n. 10 (2000); *Brenda L. Dubuque*, 55 ECAB 212, 217 (2004).

¹⁴ *Robert M. Sanford*, 27 ECAB 115 (1975).

aggravated a diagnosed condition. He merely observed that appellant was “doing fairly well” until he began his employment. This is insufficient to establish causal relationship.¹⁵

The Office referred appellant to Dr. Valentino for a second opinion examination. In a June 1, 2004 report, Dr. Valentino concluded, based on the medical history and diagnostic testing results, that appellant exhibited age-related, nonemployment-related degenerative changes in the lumbar spine. He noted that myofascial condition would have resolved with conservative care over a short period of time. Dr. Valentino also noted that physical examination findings were essentially normal with regard to appellant’s lumbar, thoracic and cervical spine. He concluded that any pathology was preexisting and a residual of appellant’s nonemployment cervical spine injury. Dr. Valentino later examined appellant upon referral by Dr. Krueger and provided a March 21, 2006 report diagnosing lumbar degenerative disc disease and residuals of cervical myelopathy. He did not support a causal relationship between appellant’s employment factors and his back condition; in fact, he attributed appellant’s low back complaints to his cervical myelopathy. Although appellant asserts that Dr. Valentino’s two reports are contradictory, the Board notes that he was consistent in finding that appellant had degenerative changes. In neither report did Dr. Valentino attribute the degenerative changes to appellant’s work activities during 2000 and 2001. The Board finds that the weight of medical opinion is represented by the reports of Dr. Valentino.

In a March 7, 2005 report, Dr. Skubick diagnosed “widespread musculoskeletal dysfunction” and noted that there was an “issue as to whether or not [appellant] has ongoing organic problems in his back.” He found Dr. Valentino’s June 1, 2004 report to be “ludicrous.” On April 19, 2005 Dr. Skubick opined that there was a direct relationship between appellant’s “musculoskeletal complaints” and the physical demands of his work. However, these reports are insufficiently rationalized to establish causal relationship. Dr. Skubick did not describe the particular employment factors identified in any detail or provide explanation concerning how specific employment factors caused appellant’s condition. He did not explain how appellant’s work duties from June 2000 to April 2001 would contribute to any preexisting disability impacting his lower extremities. Other reports by Dr. Skubick did not specifically address causal relationship.

In a March 23, 2005 report, Dr. Krueger opined that there was a direct relationship between appellant’s current complaints and the physical tasks of his former position. However, he provided insufficient explanation of the causal relationship between appellant’s condition and his employment factors. Dr. Krueger did not identify the specific physical duties involved, explain how they exceeded appellant’s capabilities, or discuss why his work factors caused or aggravated his back condition. Dr. Greene’s November 15, 2005 report attributed appellant’s condition to “problems dating back to a work activity” but he did not identify the work activity to which he referred or explain the reasons why it caused appellant’s condition. He also noted that he relied partially on appellant’s own stated medical history in reaching his conclusion that there was a causal relationship between the unspecified “work activity” and appellant’s condition. However, a medical opinion based on the claimant’s beliefs concerning causal

¹⁵ See *id.*

relationship, rather than the physician's independent reasoning, is of little probative value.¹⁶ Therefore, Dr. Greene's opinion is insufficiently rationalized to support causal relationship.

Other reports submitted by appellant, including those from Dr. Buckler and Dr. Gusa, are insufficient to establish the claim as they do not specifically address whether appellant's employment factors caused or aggravated a diagnosed condition.¹⁷

Appellant contends that the Office erred in not finding a conflict between Dr. Valentino, and his treating physician. As noted however, the reports of appellant's physicians are not well rationalized on the issue of causal relationship such that they are of diminished probative value.

CONCLUSION

The Board finds that appellant did not meet his burden of proof in establishing that he developed an occupational disease in the performance of duty.

ORDER

IT IS HEREBY ORDERED THAT the October 26, 2006 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 10, 2007
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

¹⁶ *Earl David Seal*, 49 ECAB 152, 155-56 (1997).

¹⁷ Reports from Dr. Kaye, a chiropractor, are of no probative value. A chiropractor may only be considered a physician under the Act to the extent that he or she diagnoses a spinal subluxation as demonstrated by x-ray. *See* 5 U.S.C. § 8101(2). Dr. Kaye did not diagnose a spinal subluxation as demonstrated by x-ray and is not considered a physician. *See Charley V.B. Harley*, 2 ECAB 208, 211 (1949) (where the Board held that medical opinion, in general, can only be given by a qualified physician).