United States Department of Labor
Employees' Compensation Appeals Board

A.P., Appellant	)	
and	)	**Docket No. 13-2014**
	)	**Issued: February 21, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Columbus, OH, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On September 3, 2013 appellant, through his attorney, filed a timely appeal from an April 29, 2013 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 this case.

ISSUE

The issue is whether appellant met his burden of proof to establish that his myocardial infarction and stroke were causally related to a July 26, 2012 employment incident.

FACTUAL HISTORY

On August 9, 2012 appellant, then a 62-year-old mail carrier, filed a traumatic injury claim alleging that on July 26, 2012 he passed out and fell down on concrete as a result of becoming overheated at work. He noted that a heat advisory was in effect. Appellant stated that,

[1] 5 U.S.C. § 8101 *et seq.*

when he arrived at the hospital, tests showed that he had a heart attack along with bruising on his head and the right side of his body. He stopped work on July 26, 2012.

In a July 26, 2012 hospital report, Dr. Brian S. Seifferth, Board-certified in emergency medicine, related that appellant had a syncopal episode while carrying mail at 2:00 p.m. today and hit the back of his head when he fell down. He noted that an electrocardiogram (EKG) examination verified that appellant sustained an acute myocardial infarction. Dr. Seifferth reviewed appellant's history and noted that he had surgery to remove a brain aneurysm in 2000. Upon examination, he observed abrasions on appellant's right knee and the back of his head without contusion. Appellant's extremities revealed full range of motion and no underlying tenderness. Dr. Seifferth diagnosed acute ST-wave myocardial infarction, syncope, renal insufficiency and multiple abrasions. Appellant also submitted an emergency room assessment sheet and registration form.

In a July 27, 2012 hospital report, Dr. Matthew J. Poturalski, a radiologist, reviewed appellant's hospital records and pertinent lab data, including radiographic reports and cardiovascular imaging. He related that appellant was a mailman who experienced a syncopal episode yesterday with no preceding symptoms. Upon examination, Dr. Poturalski observed regular rate and rhythm of appellant's heart with no murmurs, rubs or gallops. He also noted abrasions on appellant's right knee and the back of the head.

In a July 29, 2012 EKG report, Dr. Todd G. Matros, a Board-certified internist, who specializes in cardiovascular disease, observed normal sinus rhythm and inferior infarct. He stated that the EKG results were abnormal.

In an August 2, 2012 hospital discharge report, Dr. Steven J. Yakubov, a Board-certified internist, who specializes in cardiovascular disease, noted that appellant worked as a mailman and was admitted in the hospital on July 26, 2012 for experiencing an episode of syncope with no preceding symptoms. He related that appellant regained consciousness on the ground but passed out again when he tried to stand up. Dr. Yakubov stated that an EKG demonstrated ST-elevations and that on July 30, 2012 appellant had two stents implanted. He provided appellant's history and reported discharge diagnoses of acute myocardial infarction of the inferior wall, acute respiratory distress, benign hypertension and acute renal failure syndrome.

In an August 4, 2012 preliminary hospital report, Dr. Mohammad Naseem, a Board-certified radiologist, related appellant's complaints of right-sided weakness. He reported that a computerized tomography (CT) scan of appellant's head revealed an acute intraparenchymal hemorrhage right superior aspect cerebellar vermis along the right superior and middle cerebellar peduncles and a mild mass effect on the right lateral aspect fourth ventricle and right perimesencephalic.

In an August 4, 2012 CT scan report, Dr. Nicholas Peponis, a Board-certified diagnostic radiologist, observed evidence of right frontal craniotomy with streak artifacts associated with aneurysm. He diagnosed acute right cerebellar hematoma, mild compression of the fourth ventricle and suprasellar aneurysm clip placement changes in the right suprasellar region.

In an August 4, 2012 hospital report, Dr. Robert Montazemi, a Board-certified internist, noted that appellant was initially examined in an emergency room with acute coronary syndrome and found to have significant coronary disease. He related that yesterday appellant complained of difficulty with coordination and having problems using his right hand. Dr. Montazemi reported that a CT scan revealed an acute intracerebellar hemorrhage. He stated that his initial impression was that appellant suffered an acute cerebrovascular accident (CVA) or a stroke several days ago due to hypotension and decreased cardiac output. Dr. Montazemi diagnosed acute cerebellar hemorrhage and status post angioplasty and stent and placement of drug eluding stents as well. Appellant submitted various handwritten progress notes by Dr. Montazemi dated August 3 to 4, 2012.

In an August 5, 2012 report, Dr. Dennis A. Calnon, a Board-certified internist, who specializes in cardiovascular disease, stated that on July 26, 2012 appellant had a syncopal event and fell and hit the back of his head. He noted that appellant was diagnosed with ST-elevation myocardial infarction and had two drug eluding stents implanted. Cardiovascular examination revealed regular rhythm and normal S1 and S2 with no murmurs, rubs or gallops. Dr. Calnon reported that appellant sustained an intracranial hemorrhage and coronary arteriosclerosis.

In an August 16, 2012 letter, Sue Grice, a health and resource specialist for the employing establishment, controverted appellant's claim alleging that his heart attack and subsequent injuries from falling down were not related to his employment. She requested that OWCP deny his claim because fact of injury was not established.

In an August 19, 2012 hospital discharge report, Dr. Mohan K. Thirugnanam, a Board-certified internist, stated that appellant had a recent ST-elevation myocardial infarction in July 2012 with two stents. He noted that appellant was transferred to another hospital on August 4, 2012 for a cerebellar hemorrhage, but no surgery was needed. Appellant was transferred to rehabilitation on August 8, 2012 and was sent home on August 18, 2012. Dr. Thirugnanam reported that appellant's problems included an intracerebral hemorrhage in the right cerebellum with mild mass effect on the right lateral fourth ventricle, as confirmed by a CT scan, hypertension and hyperglycemia. He also noted appellant's history of a myocardial infarction on July 26, 2012 and a cerebral aneurysm in 2000. Dr. Thirugnanam reviewed various diagnostic and lab results.

Appellant also submitted an August 30, 2012 physical therapy evaluation report by Dr. Cart Switzer and an August 31, 2012 occupational therapy evaluation report by Andrea Wright.

By letter dated September 13, 2012, OWCP advised appellant that the evidence submitted was insufficient to establish his traumatic claim. It requested additional information to establish that the July 26, 2012 incident occurred as alleged and that he sustained a diagnosed condition as a result of the work incident.

In a statement dated September 24, 2012, appellant explained that on the date of injury it was very hot and humid and a heat advisory was in effect. He noted that he had a heart attack and fell down onto a concrete sidewalk hitting the back of his head and right knee. Appellant believed that he fell down because he became overheated and dizzy. He stated that he had no

history of fainting spells, heart condition or epileptic seizures. Appellant resubmitted his hospital records dated July 26 to August 7, 2012.

In a September 12, 2012 attending physician's report, Dr. Yakubov noted a date of injury of July 26, 2012 and related that appellant had hyperlipidemia. He diagnosed acute myocardial infarction. Dr. Yakubov reported that appellant was hospitalized from July 26 to August 2, 2012 and underwent a heart catheterization with stenting. He stated that appellant was totally disabled beginning July 26, 2012.

In a September 14, 2012 CT scan report, Dr. Sumit Seth, a Board-certified diagnostic radiologist, reported that appellant's previously identified hemorrhage involving the superior aspect of the right cerebellum had nearly completely resolved.

Appellant submitted various claims for wage-loss compensation beginning September 9, 2012.

In a decision dated November 5, 2012, OWCP denied appellant's claim. It accepted that the July 26, 2012 incident occurred as alleged and that he had a diagnosed condition but denied the claim finding that his injury did not occur in the performance of duty. OWCP stated that the evidence indicated that appellant sustained a myocardial infarction due to a personal condition and that the medical condition did not arise during the course of employment.

In a letter dated November 8, 2012, appellant's attorney requested a telephone hearing. He resubmitted diagnostic and hospital reports from July and August 2012 and various physical therapy treatment notes.

By letter dated November 26, 2012, OWCP advised appellant that it could not pay disability compensation because his traumatic injury claim was formally denied. It informed him that if he wanted to have his compensation claim paid he would have to file an appeal.

On February 12, 2013 a telephone hearing was held. Appellant was represented by his attorney, who contended that appellant sustained a heart attack and fell down due to the hot conditions on July 26, 2012. Counsel pointed out records that demonstrated the temperature was 95 degrees that day. He stated that, if not for the hot day and the activities of delivering mail, appellant would not have suffered a myocardial infarction. Counsel also alleged that appellant's cerebral hemorrhage and subsequent stroke were also related to his fall at work. Appellant described the work duties he performed on July 26, 2012 and the medical treatment he received. He noted that he did not have a prior history of cardiovascular disease, chest pain or fainting spells.

In a February 19, 2013 report, Dr. Vipin Koshal, a Board-certified internist who specializes in cardiovascular disease, related that appellant worked as a mail carrier and that on a very hot day on July 26, 2012 he suffered a myocardial infarction requiring stents to both his right coronary artery and left anterior descending coronary artery with adjunctive balloon angioplasty to the diagonal. He noted that appellant fell and lost consciousness. Dr. Koshal stated that a few days after appellant's stent procedure he was brought back to the hospital due to right-sided weakness and was found to have an intracranial hemorrhage that was thought to have been suffered from his original fall during his myocardial infarction. He opined that it was quite

possible that excessive dehydration and exertion on a very hot day triggered appellant's myocardial infarction. Dr. Koshal explained that there were many factors at play that could cause a myocardial infarction and that this was merely one of them.

By decision dated April 29, 2013, an OWCP hearing representative affirmed the November 5, 2012 denial decision as modified. It found that the medical evidence was insufficient to establish that appellant's heart attack and consequential injuries were causally related to the July 26, 2012 employment incident.

LEGAL PRECEDENT

An employee seeking benefits under FECA[2] has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative and substantial evidence[3] including that he or she sustained an injury in the performance of duty and that any specific condition or disability for work for which he or she claims compensation is causally related to that employment injury.[4]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether "fact of injury" has been established.[5] There are two components involved in establishing the fact of injury. First, the employee must submit sufficient evidence to establish that he actually experienced the employment incident at the time, place and in the manner alleged.[6] Second, the employee must submit evidence, generally only in the form of probative medical evidence, to establish that the employment incident caused a personal injury.[7] An employee may establish that the employment incident occurred as alleged but fail to show that his disability or condition relates to the employment incident.[8]

Whether an employee sustained an injury in the performance of duty requires the submission of rationalized medical opinion evidence.[9] The opinion of the physician must be based on a complete factual and medical background of the employee, 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 employee.[10] The weight of the medical evidence is determined by its reliability, its probative

[2] 5 U.S.C. §§ 8101-8193.

[3] *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

[4] *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[5] *S.P.*, 59 ECAB 184 (2007); *Alvin V. Gadd*, 57 ECAB 172 (2005).

[6] *Bonnie A. Contreras*, 57 ECAB 364 (2006); *Edward C. Lawrence*, 19 ECAB 442 (1968).

[7] *David Apgar*, 57 ECAB 137 (2005); *John J. Carlone*, 41 ECAB 354 (1989).

[8] *T.H.*, 59 ECAB 388 (2008); *see also Roma A. Mortenson-Kindschi*, 57 ECAB 418 (2006).

[9] *See J.Z.*, 58 ECAB 529 (2007); *Paul E. Thams*, 56 ECAB 503 (2005).

[10] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 465 (2005).

value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.[11]

ANALYSIS

Appellant alleged that on July 26, 2012 he sustained a heart attack and fell down on his head and knees in the performance of duty. He also alleged that he sustained a stroke a few days later as a result of the July 26, 2012 heart attack and fall at work. OWCP accepted that the July 26, 2012 incident occurred as alleged and that he suffered a heart attack and stroke but denied appellant's claim finding insufficient medical evidence to establish that his heart attack and subsequent conditions resulted from the July 26, 2012 employment incident.

Appellant was initially admitted in the hospital from July 26 to August 2, 2012 for a heart attack. In July 26 and 27, 2012 reports, Drs. Seifferth and Poturalski stated that appellant sustained a myocardial infarction and fell down while he was delivering mail. Both physicians reviewed various lab reports and noted that an EKG verified that appellant had an acute myocardial infarction. Upon examination, Dr. Seifferth observed abrasions on appellant's right knee and the back of his head. He diagnosed acute ST-wave myocardial infarction, syncope, renal insufficiency and multiple abrasions. In an August 2, 2012 discharge summary report, Dr. Yakubov accurately described the July 26, 2012 incident at work and reported discharge diagnoses of acute myocardial infarction of the inferior wall, acute respiratory distress, benign hypertension and acute renal failure syndrome. Drs. Seifferth, Poturalski, and Yakubov accurately described the July 26, 2012 incident at work and diagnosed acute myocardial infarction. None of the physicians, however, provided any opinion on the cause of appellant's heart condition and abrasions. While they mention the July 26, 2012 employment incident, the physicians do not opine that appellant's heart attack and subsequent fall were causally related to delivering mail or the excessive heat on July 26, 2012. The Board has held that medical evidence that does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[12] These medical reports, therefore, are insufficient to establish appellant's claim.

Appellant returned to the hospital on August 3, 2012 where he was admitted for approximately two weeks. In August 3 and 4, 2012 hospital reports, Drs. Montazemi and Naseem stated that appellant sustained a syncopal event when he was at work as a mailman and was treated for acute coronary syndrome. They noted that appellant returned yesterday with complaints of difficulty with coordination. Both physicians reported that a CT scan of appellant's head revealed an acute intracerebellar hemorrhage and a mild mass effect on right lateral aspect fourth ventricle and right perimesencephalic. Dr. Montazemi opined that appellant suffered an acute CVA or a stroke. In an August 5, 2012 report, Dr. Calnon stated that on July 26, 2012 appellant had a myocardial infarction and then sustained an intracranial hemorrhage. In an August 19, 2012 hospital discharge report, Dr. Thirugnanam noted

[11] *James Mack*, 43 ECAB 321 (1991).

[12] *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *J.F.*, Docket No. 09-1061 (issued November 17, 2009); *A.D.*, 58 ECAB 149 (2006).

appellant's history of a myocardial infarction on July 26, 2012 and that he was seen again on August 4, 2012 for a cerebellar hemorrhage.

Although Drs. Montazemi, Naseem, Calnon, and Thirugnanam describe the July 26, 2012 heart attack and diagnose that appellant sustained a stroke a few days later, none of the physicians opine or explain that his stroke was causally related to the July 26, 2012 employment incident. Because none of the physicians provide any opinion on the cause of appellant's stroke, these hospital records are insufficient to establish his claim. Likewise, the diagnostic reports by Drs. Seth, Peponis and Matros also fail to include any opinion on the cause of appellant's heart condition and stroke and are insufficient to establish his claim.[13] Although appellant believes that the excessive heat on July 26, 2012 caused or contributed to his heart attack and fall at work and subsequent stroke, his belief alone is insufficient to establish his claim.[14]

Appellant also submitted a February 19, 2013 report by Dr. Koshal who related that appellant worked as a mailman and described the July 26, 2012 incident at work. Dr. Koshal noted that appellant suffered a myocardial infarction and fell down. He reported that a few days later appellant returned to the hospital where he was treated for an intracranial hemorrhage that was believed to have resulted from his heart attack and subsequent fall. Dr. Koshal opined that it was quite possible that excessive dehydration and exertion on a hot day triggered appellant's heart condition. He stated that, while there were many factors that could have contributed to appellant's myocardial infarction, this was merely one of the factors.

The Board notes that Dr. Koshal provided an accurate history of injury and medical diagnosis. Dr. Koshal's opinion, however, that it was "quite possible" that appellant's heart attack resulted from excessive dehydration and exertion is speculative and does not clearly explain how the July 26, 2012 work incident caused or contributed to his heart condition and subsequent injuries. The Board has held that medical opinions that are speculative or equivocal in character are of diminished probative value.[15] Because Dr. Koshal's opinion is of diminished probative value, this report is insufficient to establish appellant's claim. On appeal, appellant alleges that Dr. Koshal opined that exertion in excessive heat can trigger a myocardial infarction. As stated above, however, Dr. Koshal failed to provide a clear and unequivocal opinion explaining how the July 26, 2012 employment incident caused or contributed to appellant's conditions. An award of compensation may not be based on surmise, conjecture, speculation or upon appellant's own belief that there is causal relationship between his claimed condition and his employment.[16]

Appellant also submitted physical therapy and occupational therapy evaluation reports. Physical and occupational therapists, however, are not "physicians" as defined by FECA.

[13] *Id.*

[14] *Jennifer Atkerson,* 55 ECAB 317 (2004).

[15] *D.D.*, 57 ECAB 734, 738 (2006); *Kathy A. Kelley,* 55 ECAB 206 (2004).

[16] *Robert A. Boyle,* 54 ECAB 381 (2003); *Patricia J. Glenn*, 53 ECAB 159 (2001).

Accordingly, their medical opinions regarding diagnosis and causal relationship are of no probative medical value.[17]

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.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that his heart condition and stroke were causally related to the July 26, 2012 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the April 29, 2013 merit decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 21, 2014
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[17] 5 U.S.C. § 8101(2); *Roy L. Humphrey*, 57 ECAB 238 (2005).