United States Department of Labor
Employees' Compensation Appeals Board

J.K., Appellant	)	
and	)	**Docket Nos. 10-2355 & 10-2362**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRATION, Huntington, WV, Employer	)	**Issued: August 23, 2011**

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On September 20, 2010 appellant filed a timely appeal of a June 28, 2010 decision of the Office of Workers' Compensation Programs, which denied his request for disability for the period October 17 to 31, 2009. Appellant also appealed from a May 4, 2010 OWCP decision that denied disability for the period October 5 to 16, 2009.[1] Pursuant to the Federal Employees' Compensation Act[2] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] The record contains a June 10, 2010 decision, in which OWCP denied appellant's request for carpal tunnel release surgery. Appellant has not appealed this decision.

[2] 5 U.S.C. § 8101 *et seq.*

ISSUE

The issue is whether appellant met his burden of proof to establish that he was disabled for the periods October 5 to 16 and October 17 to 31, 2009, as a result of his employment-related conditions.

FACTUAL HISTORY

On August 28, 2008 appellant, then a 51-year-old nurse, filed a traumatic injury claim alleging that on that date, he injured his left wrist, forearm and aggravated a preexisting injury to his low back while trying to catch boxes of copier paper that fell from a cart. He stopped work and returned to full duty on September 8, 2008.[3] On October 15, 2008 OWCP accepted the claim for sprain of the back in the lumbar region. On July 7, 2009 it accepted left carpal tunnel syndrome and lesion of the left ulnar nerve.[4]

Appellant received treatment from Dr. Mark S. Calfee, a chiropractor. On July 24, 2009 Dr. Calfee requested additional treatment and authorization for an electromyogram/nerve conduction velocity (EMG/NCV) study. He continued to treat appellant and recommend conservative care.

In an August 5, 2009 report, Dr. David L. Caraway, a Board-certified anesthesiologist and pain management specialist, noted that the lumbar magnetic resonance imaging (MRI) scan disclosed disc bulges at L2-3, L3-4 and L4-5. He recommended epidural spinal injections as well as an upper extremity EMG. On August 7, September 2 and 15 and October 22, 2009 Dr. Caraway treated appellant with lumbar epidural steroid injections.

In a September 16, 2009 report, Dr. Calfee noted that appellant had left shoulder pain and significant low back pain. He advised that appellant continued to present with positive and subjective findings. Dr. Calfee recommended that because of the "ongoing nature" of his condition, appellant perform work-related activities from home until he was able to return to work on a full duty schedule without restrictions. He indicated that the period of time should extend through the end of October with a return to work date of November 2, 2009. Dr. Calfee advised that, if appellant's condition improved, he would be released to full duty at the appropriate time.

[3] Appellant sustained a prior work-related injury on July 5, 2006 when a patient grabbed his left wrist. Under file number xxxxxxx478 OWCP accepted the conditions left forearm sprain, left wrist sprain, left carpal tunnel syndrome, left ulnar nerve lesion, left wrist tenosynovitis and left ulnar nerve injury. This claim is not before the Board on the present appeals.

[4] On May 28, 2009 OWCP referred appellant for a second opinion, along with a statement of accepted facts, a set of questions and the medical record to Dr. Edward G. Fisher, a Board-certified orthopedic surgeon. In a June 30, 2009 report, Dr. Fisher noted appellant's history of injury and treatment. He examined appellant and diagnosed left carpal tunnel syndrome and left ulnar neuropathy. Dr. Fisher opined that appellant could work full time with restrictions as to repetitive wrist movement and lifting.

On October 14, 2009 appellant submitted a Form CA-7 requesting wage-loss compensation for disability for the period October 5 to 16, 2009. The employing establishment advised that he had been off work since July 2, 2009.

By letter dated October 20, 2009, OWCP informed appellant of the evidence needed to support his claim of disability from October 5 to 16, 2009 and requested that he submit such evidence within 30 days.

In a report dated October 29, 2009, Dr. Luis E. Bolano, a Board-certified orthopedic surgeon diagnosed carpal tunnel and cubital tunnel syndrome. He advised that appellant needed surgery for his left carpal tunnel and ulnar conditions. Dr. Bolano noted that appellant was working full time.

On October 27, 2009 appellant submitted a Form CA-7 requesting wage-loss compensation for disability for the period October 17 to 31, 2009.

In a report dated November 2, 2009, Dr. Calfee advised that appellant continued to have low back pain with radicular symptoms into the left lower extremity with associated muscle spasticity. Appellant also experienced pain and loss of function of the left upper extremity with associated neuropathy and associated dysfunction of the hand. Dr. Calfee noted that appellant was on temporary total disability for an extended period and released to return to work effective November 2, 2009 with restrictions. In a separate report also dated November 2, 2009, he explained that appellant presented with restricted range of motion in the lumbopelvic region with diminished reflexia in the left patella at plus one. Dr. Calfee noted that the right patella and Achilles reflexes were within normal limits, a positive Valsalva response and Bechterew on the left, and straight leg raising in the supine posture of approximately 30 degrees with associated lumbosacral pain. He stated that appellant had been disabled from July 7 through November 1, 2009.

In a report dated November 5, 2009, Dr. Caraway noted that appellant reported left-sided low back pain in the left leg, foot, left arm, elbow and hand pain. He diagnosed sprain/strain of the back and lumbar region, carpal tunnel syndrome and ulnar nerve.

In a letter dated November 12, 2009, OWCP requested additional information. It noted that clarification was required as to why appellant was unable to go to work, but able to perform his duties at home.

By decision dated November 25, 2009, OWCP denied appellant's claim for compensation for the period October 5 to 16, 2009 due to insufficient medical evidence. It also found that Dr. Calfee did not diagnose a spinal subluxation based on x-ray.

In a letter dated December 4, 2009, appellant's representative requested a telephone hearing, which was held on March 5, 2010. During the hearing, appellant stated that he fell at work on July 6, 2009 and stopped through October 2009. He returned to work in November 2009 after using all of his accrued annual and sick leave. Appellant's representative advised that he would file a CA-1 regarding the July 2009 fall at work as it was a new intervening incident.

By decision dated December 9, 2009, OWCP denied appellant's claim for compensation for the period from October 17 to 31, 2009. It found the medical evidence did not establish his disability for this period. OWCP also found that Dr. Calfee was not a physician as he did not diagnose any spinal subluxation.

In a report dated December 10, 2009, Dr. Bolano diagnosed carpal tunnel syndrome and ulnar nerve neuropathy and advised that appellant was currently being treated for his August 28, 2008 work-related injury. He noted that appellant "was off work until November 2[, 2009] due to the exacerbation of his symptoms: Constant numbness and tingling of left fingers, constant and severe burning pain from left elbow down to left wrist, constant and severe pain around left scapula and limited range of motion of the left upper extremity." Dr. Bolano noted that surgery was delayed due to a delay in approval of physical therapy.

On December 11, 2009 OWCP received a letter from appellant addressing the reasons for his disability.

In a letter dated December 21, 2009, appellant's representative requested a telephonic hearing, which was held on March 23, 2010. In a February 19, 2010 report, Dr. Calfee noted appellant's history and findings on examination. X-rays of appellant's lumbar spine revealed spinal biomechanical alterations, facet tropism at L4-L5 and L5-S-1, facet arthrosis at the lower lumbar spine and there was mild spondylosis present throughout. Dr. Calfee diagnosed subluxation of the lower lumbar spine with associated sprain/strain injury and radiculitis. He opined that the wrenching nature of appellant's injury resulted in rotational malposition of the lower lumbar spinal segments. Dr. Calfee noted that due to the ongoing nature of his condition and continued positive subjective and objective findings, appellant's treatment was extended beyond the initial eight-week program of care. He opined that appellant required ongoing treatment of the low back and left upper extremity due to the injuries sustained. Dr. Calfee indicated that appellant was released to return to work. He noted that sitting for long periods, bending and twisting of the waist, repetitive motion to the left wrist and reaching over the head was not recommended. Dr. Calfee indicated that appellant could not lift more than 25 pounds.

In a May 4, 2010 decision, OWCP's hearing representative affirmed the November 25, 2009 decision. In a June 28, 2010 decision, another OWCP hearing representative affirmed the December 9, 2009 decision.

LEGAL PRECEDENT

The term disability as used in FECA means the incapacity because of an employment injury to earn the wages that the employee was receiving at the time of injury.[5] Whether a particular injury caused an employee disability for employment is a medical issue which must be resolved by competent medical evidence.[6] When the medical evidence establishes that the residuals of an employment injury are such that, from a medical standpoint, they prevent the employee from continuing in the employment held when injured, the employee is entitled to

[5] *See* 20 C.F.R. § 10.5(f).

[6] *Paul E. Thams*, 56 ECAB 503 (2005); *W.D.*, Docket No. 09-658 (issued October 22, 2009).

compensation for any loss of wage-earning capacity resulting from such incapacity.[7] The Board will not require OWCP to pay compensation for disability in the absence of any medical evidence directly addressing the specific dates of disability for which compensation is claimed. To do so would essentially allow employee's to self-certify their disability and entitlement to compensation.[8]

Generally, findings on examination are needed to justify a physician's opinion that an employee is disabled for work.[9] The Board has stated that, when a physician's statements regarding an employee's ability to work consists only of a repetition of the employee's complaints that he or she hurt too much to work, without objective signs of disability being shown, the physician has not presented a medical opinion on the issue of disability or a basis for payment of compensation.[10] The Board has held that a medical opinion not fortified by medical rationale is of little probative value[11]

ANALYSIS

Appellant claimed disability from October 5 to 16 and 17 to 31, 2009 as being due to his August 28, 2008 work injury. He provided several medical reports but they do not support his claim for total disability as a result of the accepted employment injuries. The Board also notes that, on July 6, 2009, appellant indicated that he fell at work and stopped. His representative is in the process of filing a separate traumatic injury claim for that event. None of the medical reports submitted by appellant addressed this subsequent injury and its impact on a claim for disability after this period.

The evidence includes several reports from appellant's treating chiropractor, Dr. Calfee. Section 8101(2) of FECA[12] provides that the term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist and subject to regulation by the Secretary.[13] As Dr. Calfee provided a diagnosis of a subluxation from x-ray in his February 19, 2010 report, he is considered a physician under FECA with regard to treatment of appellant's lumbar spine. He is not a physician with regard to other accepted conditions, such as disorders of the wrists or upper extremities.[14] In a February 19, 2010 report, Dr. Calfee advised that the wrenching nature of appellant's injury resulted in rotational malposition of the lower

[7] *Id*.

[8] *William A. Archer*, 55 ECAB 674 (2004); *Fereidoon Kharabi*, 52 ECAB 291 (2001).

[9] *See Dean E. Pierce*, 40 ECAB 1249 (1989); *Paul D. Weiss*, 36 ECAB 720 (1985).

[10] *John L. Clark*, 32 ECAB 1618 (1981).

[11] *See George Randolph Taylor*, 6 ECAB 986, 988 (1954).

[12] 5 U.S.C. § 8101(2).

[13] *See* 20 C.F.R. § 10.311.

[14] *George E. Williams*, 44 ECAB 530, 534 (1993).

lumbar spinal segments and that the ongoing nature of appellant's condition along with continued positive subjective and objective findings, required ongoing treatment beyond the initial eight weeks of care. He released appellant to work with restrictions. This report is of limited probative value as Dr. Calfee did not address how the accepted lumbar condition from the August 28, 2008 injury caused disability on the claimed dates in 2009. He also did not show an awareness of the July 6, 2009 fall at work or address its impact on appellant's condition. It is well established that medical reports must be based on a complete and accurate factual and medical background and medical opinions based on an incomplete or inaccurate history are of little probative value.[15]

In a September 16, 2009 report, Dr. Calfee recommended that, because of the "ongoing nature" of his condition, appellant should perform his work-related activities from home until which time he was able to return to work on a full duty schedule with no restrictions. He noted that appellant should return to work November 2, 2009. In reports dated November 2, 2009, Dr. Calfee advised that appellant continued to have low back pain with radicular symptoms into the left lower extremity with associated muscle spasticity. He also related that appellant experienced pain and loss of function of the left arm and hand. Dr. Calfee found that appellant was disabled and released him to work effective November 2, 2009 with restrictions. He explained that appellant presented with restricted range of motion in the lumbopelvic region with diminished reflexia in the left patellar at plus one. OWCP requested that Dr. Calfee clarify his opinion as to why appellant could only perform work at home as opposed to at the employing establishment but Dr. Calfee did not provide a response. The Board finds that Dr. Calfee did not provide a reasoned medical opinion addressing how appellant's lumbar condition from the August 28, 2008 injury caused total disability during the claimed periods. His opinion is of limited probative value and insufficient to establish appellant's claim.

In a report dated October 29, 2009, Dr. Bolano, diagnosed carpal tunnel and cubital tunnel syndrome and noted that appellant needed surgery for his left carpal tunnel and ulnar conditions. However, he indicated that appellant was working full time. This report does not support disability for the aforementioned period. In his December 10, 2009 report, Dr. Bolano diagnosed carpal tunnel syndrome and ulna nerve neuropathy and advised that appellant was currently being treated for his August 28, 2008 work-related injury. He noted that appellant "was off work until November 2[, 2009] due to the exacerbation of his symptoms" that he listed. The Board notes that this report contradicts Dr. Bolano's earlier report in which he advised that appellant was working full time and there is no indication that he is aware of the July 6, 2009 fall as he did not address its impact on appellant's condition. Furthermore, Dr. Bolano does not otherwise provide a rationalized explanation regarding why the August 28, 2008 injury caused total disability during the claimed periods. Thus, it is of limited probative value.

Appellant also submitted treatment records from Dr. Caraway. The records are insufficient to establish the claim as Dr. Caraway did not specifically address how the August 28, 2008 injury caused total disability during the claimed periods at issue. Likewise, other reports

[15] *Douglas M. McQuaid*, 52 ECAB 382 (2001).

submitted by appellant also did not address whether his accepted condition caused disability for the claimed periods.[16]

Although appellant alleged that he was disabled for the periods October 5 to 16 and October 17 to 31, 2009, due to his accepted August 28, 2008 employment injury, the medical evidence of record does not establish that his claimed disability during the above timeframes was related to his accepted employment injuries. The Board finds that appellant has failed to submit rationalized medical evidence establishing that his claimed disability was causally related to his accepted employment injury and thus, he has not met his burden of proof.

CONCLUSION

The Board finds that appellant failed to establish that he was disabled for the periods October 5 to 16 and October 17 to 31, 2009, as a result of his employment-related conditions.

ORDER

IT IS HEREBY ORDERED THAT the June 28 and May 4, 2010 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: August 23, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[16] *See J.F.*, Docket No. 09-1061 (issued November 17, 2009) (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). *K.W.*, 59 ECAB 271 (2007).