

**United States Department of Labor  
Employees Compensation Appeals Board**

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**RICHARD E. BURREINGTON, Appellant**

**and**

**U.S. POSTAL SERVICE, SHARED SERVICE  
CENTER, Pittsburgh, PA, Employer**

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**Docket No. 06-62  
Issued: February 7, 2006**

*Appearances:*

*Thomas R. Uliase, Esq., for the appellant  
Office of Solicitor, for the Director*

*Case Submitted on the Record*

**DECISION AND ORDER**

Before:

DAVID S. GERSON, Judge  
MICHAEL E. GROOM, Alternate Judge

**JURISDICTION**

On October 4, 2005 appellant, through his attorney, filed a timely review of a merit decision of the Office of Workers' Compensation Programs' hearing representative dated May 23, 2005, which found that he had failed to establish fact of injury. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(d), the Board has jurisdiction over the merits of the claim.

**ISSUE**

The issue is whether appellant has established that he sustained an injury on March 6, 2004 causally related to a traffic accident while in the performance of duty.

**FACTUAL HISTORY**

On March 10, 2004 appellant, then a 59-year-old city carrier, filed a Form CA-1 claim for traumatic injury alleging that on March 6, 2004 while performing his duties, his postal vehicle was hit in the rear by another motor vehicle. He sustained muscle strain injuries of the back and neck. Appellant stopped work on March 6, 2004 and returned on March 7, 2004.

On March 8, 2004 appellant received thoracic and cervical x-rays. They were read on March 10, 2004 by Dr. Russell Golkow, a Board-certified radiologist, as demonstrating mildly

accentuated thoracic kyphosis and advanced generalized spondylosis, but no fracture, dislocation or other abnormality. The cervical spine revealed no fracture, dislocation or loss of vertebral stature, but there was mild loss of C6-7 disc space stature. Dr. Golkow diagnosed kyphosis and spondylosis of the thoracic spine and degenerative disc pathology at C6-7.

On March 8, 2004 appellant sought treatment with a chiropractor whose signature is illegible and who did not present a diagnosis or addressing x-rays. He opined that appellant could carry 20 pounds per day, sit for 6 hours a day and stand and walk for 3 hours per day.

In a report dated March 29, 2004, Dr. John M. Gray, a Board-certified orthopedic surgeon, diagnosed medial arthritis and noted examination findings as “tender [and] swollen.” He ordered a brace and anti-inflammatories and indicated that appellant was to return to see him in one month.

By decision dated April 12, 2004, the Office rejected appellant’s claim, finding that he failed to establish fact of injury. The Office found that, although the evidence established that appellant experienced the claimed incident, there was insufficient medical evidence to establish that a condition had been diagnosed resulting from the employment incident.

On April 16, 2004 appellant, through his representative, requested an oral hearing.

On May 20, 2004 the Office received unsigned treatment notes dated April 13 and 15, 2004 from Dr. Thomas Bickel, a chiropractor. He noted that an x-ray study revealed a degenerative disc at the C7 spinal level and arthritic changes in the thoracic spine. Dr. Bickel diagnosed rotational misalignments and subluxations by palpation.

In a June 7, 2004 letter, appellant’s representative stated that appellant had experienced a second injury on March 6, 2004, which involved being struck from behind while in his postal vehicle, which aggravated his preexisting left knee condition.

Appellant provided reports from Dr. Gray dated December 10, 2003 through February 23, 2004. He noted that appellant underwent an arthroscopic partial medial meniscectomy for a complex tear of the left medial meniscus, had started to heal, experienced some complications and underwent physical therapy. After several postoperative visits and physical therapy, appellant saw Dr. Gray again on March 29, 2004. Dr. Gray noted that appellant was “doing okay,” that he “continued to complain of some swelling and unfortunately, he had another incident, somebody struck him in the posterior aspect of his truck and he jammed the leg, he now has pain, swelling and he continued to have some problems with it.” Continued light duty was recommended with return for examination in one month.

In a March 6, 2004 emergency room evaluation, appellant was treated by Dr. Alan Dias, an emergency room resident. A computerized tomography (CT) scan was ordered of appellant’s head and was reported as being normal. Nursing and emergency room intake notes were also submitted.

An August 9, 2004 report from Dr. Lawrence I. Barr, an osteopathic physician, noted that he had treated appellant following the motor vehicle accident. He noted appellant’s injuries at the time of the accident, as noted by Virtua Memorial Hospital, included an injured neck and

upper back and an injured left knee. Dr. Barr found tenderness to palpation along the entire posterior cervical musculature and into both trapezii. He found marked spasm throughout the cervical musculature and 70 percent range of normal cervical spine motion. Extremes of motion were painful, reflex tests were negative, strength was intact and x-rays showed degenerative changes at C6-7. Dr. Barr diagnosed cervical sprain with superimposed degenerative disc disease at C6-7 and thoracic strain with superimposed spondylosis. He opined that appellant continued to be symptomatic from the March 6, 2004 motor vehicle accident and recommended therapy, conditioning and strengthening. Full duty was also recommended.

In a November 1, 2004 report, Dr. Barr noted that he examined appellant that date. Following physical therapy, appellant had been doing quite well and had no midback pain, but experienced neck discomfort at times without radiating pain down his arms. Dr. Barr noted that examination of the cervical spine revealed a range of motion, no tenderness or muscle spasm, no masses, no tenderness upon compression of the cervical spine, a negative Spurling maneuver, a negative Hoffman sign, full range of motion in all upper extremity joints and normal motor, sensory and reflex examinations. Appellant alleged discomfort with rotation to the left and right. The thoracic spine revealed no evidence of tenderness or muscle spasm and forward bending revealed no evidence of scoliosis or deformity. He diagnosed “resolved cervical and thoracic sprains,” and indicated that appellant could work full duty.

An unsigned February 9, 2005 report from Dr. Bickel noted that he treated appellant on March 8, 2004 for injuries sustained in a motor vehicle accident on March 6, 2004. Appellant’s diagnoses included cervical sprain/strain, cervicobrachial syndrome, thoracic spine sprain/strain and muscle spasms. At appellant’s most recent visit, he described neck pain, headaches, upper back pain, middle back pain and lower back pain. Dr. Bickel stated that appellant had painful and restricted ranges of motion in his cervical, thoracic and lumbar spines. He last saw appellant on August 28, 2004 and was unable to determine whether appellant had any permanent injury from the March 6, 2004 motor vehicle incident. Dr. Bickel opined that his findings revealed objective evidence that appellant continued to experience pain and restrictions of spinal motion.

An oral hearing was held on February 24, 2005 at which appellant testified.

By decision dated May 23, 2005, an Office hearing representative found that appellant failed to submit sufficient medical evidence to establish fact of injury on March 6, 2004.

### **LEGAL PRECEDENT**

An employee seeking benefits under the Federal Employees’ Compensation Act<sup>1</sup> 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 filed within the applicable time limitation 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 are causally related to the employment injury.<sup>2</sup>

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<sup>1</sup> 5 U.S.C. § 8101 *et seq.*

<sup>2</sup> *Elaine Pendleton*, 40 ECAB 1143 (1989).

Fact of injury consists of two components which must be considered in conjunction with one another. The first component to be established is that the employee actually experienced the employment incident which is alleged to have occurred.<sup>3</sup> The second component is whether the employment incident caused a personal injury and can generally be established only by medical evidence. To establish a causal relationship between a condition and any attendant disability claimed and the employment event or incident, the employee must submit rationalized medical opinion evidence based on a complete factual and medical background supporting such a causal relationship.

Rationalized medical opinion evidence is medical evidence that 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. Such an 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 appellant.<sup>4</sup>

The medical evidence should identify and support a causal relation on the basis of its pathophysiology, explaining such that a nonmedical person can visualize and understand its connectedness. To be of probative value, the physician must provide rationale for the opinion reached. Where no such rationale is present, the medical opinion is of diminished probative value.<sup>5</sup>

Section 8101(2) of the Act<sup>6</sup> 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."

### ANALYSIS

In this case, the Office accepted that appellant experienced the March 6, 2004 employment incident at the time, place and in the manner alleged. However, appellant has submitted insufficient medical evidence to establish that the employment incident caused a personal injury.

The most contemporaneous medical evidence appellant submitted was the March 6, 2004 emergency room evaluation where appellant was treated by Dr. Dias. He ordered a CT scan of appellant's head and it was reported as being normal. No other emergency room report addressed the nature and extent of his medical conditions that date. No specific diagnosis was offered nor causal relationship discussed.

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<sup>3</sup> For a detailed discussion of the components of appellant's burden of proof in establishing fact of injury see *Elaine Pendleton*, *supra* note 2.

<sup>4</sup> See *Donna Faye Cardwell*, 41 ECAB 730 (1990); *Lillian Cutler* 28 ECAB 125 (1976).

<sup>5</sup> *Lucrecia M. Nielsen*, 42 ECAB 583 (1991).

<sup>6</sup> 5 U.S.C. § 8101(2).

On March 8, 2004 appellant underwent cervical and thoracic x-rays, which were read on March 10, 2004 by Dr. Golkow as revealing, respectively, no fracture, dislocation or loss of vertebral stature. A mild loss of C6-7 disc space and mildly accentuated thoracic kyphosis and advanced generalized spondylosis were noted, but no fracture, dislocation or other abnormality. Dr. Golkow diagnosed kyphosis and spondylosis of the thoracic spine and degenerative disc pathology at C6-7. He did not relate any of these diagnosed spinal conditions to the traumatic incident of March 6, 2004. Therefore, this medical evidence does not establish that appellant sustained a injury.

On March 8, 2004 appellant sought treatment with a chiropractor who provided an illegible signature, making it impossible to establish who the author was. As authorship cannot be established, the report is of no probative value.<sup>7</sup>

On March 29, 2004 appellant was treated by his former knee surgeon, Dr. Gray who had been following appellant postoperatively for residuals of a left knee arthroscopic surgery performed for a torn meniscus in December 2003. He noted that appellant was “doing okay,” and that complained of some swelling. Dr. Gray indicated that somebody struck appellant in the posterior aspect of his truck and jammed the leg, with pain and swelling. Dr. Gray recommended continued light duty for appellant. No injury-specific diagnosis was provided. He did not address causal relationship between the motor vehicle accident except for noting that appellant jammed his left leg and now had pain and swelling and “problems.” As this report did not discuss causal relationship with the motor vehicle accident and explain how it aggravated the preexisting pathology in appellant’s knee, it is of reduced probative value and insufficient to establish that appellant sustained a diagnosed left knee injury, causally related to the March 6, 2004 traffic incident.

On March 29, 2004 Dr. Gray diagnosed medial arthritis, noted that examination findings as “tender and swollen,” and ordered a brace. This report does not contain any history of the March 6, 2004 incident or explanation of how such incident caused or contributed to the medical arthritis. The symptoms of tenderness and swelling appear related to the medial arthritis but it is not clear from the report what portion of the knee was swollen or where it was tender. Dr. Gray’s report does not offer a diagnosis of injury related to the accept incident. It is of diminished probative value in establishing that an injury was sustained on March 6, 2004 as alleged. The other reports of the physician predate the March 6, 2004 incident and are not relevant to the disposition of this issue.

Appellant submitted unsigned reports from Dr. Bickel, a chiropractor. He noted that x-ray studies were obtained and revealed a degenerative disc at C7 and arthritic changes in the thoracic spine. As these reports are unsigned, they are of no probative value.<sup>8</sup>

An August 9, 2004 report from Dr. Barr, dated five months from the date of incident referred back to the emergency room paperwork. Dr. Barr diagnosed a neck injury, upper back injury and an injured left knee. He did not discuss the details for making these diagnoses or

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<sup>7</sup> See *Merton J. Sills*, 39 ECAB 572 (1988).

<sup>8</sup> *Id.*

address the issue of causal relationship. Dr. Barr reported findings on examination in August 2004, which included tenderness to palpation along the posterior cervical musculature with spasm and a 70 percent range of motion. However, he did not explain how these physical findings were causally related to the motor vehicle accident five months earlier. Dr. Barr diagnosed cervical strain with superimposed degenerative disc disease, degenerative disc disease at C6-7 and thoracic strain with superimposed spondylosis. Dr. Barr failed to address how these strains related to the traumatic incident. He also failed to fully explain upon what basis these strains were diagnosed. Dr. Barr's diagnoses were made months after the fact and without a discussion of the basis for his opinion on causal relationship. His reports are of diminished probative value. Consequently, Dr. Barr's opinion is insufficient to establish appellant's claim.

### **CONCLUSION**

The Board finds that appellant has failed to establish an injury related to the March 6, 2004 motor vehicle accident.

### **ORDER**

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs' hearing representative dated May 23, 2005 is affirmed.

Issued: February 7, 2006  
Washington, DC

David S. Gerson, Judge  
Employees' Compensation Appeals Board

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