

FACTUAL HISTORY

On December 8, 2007 appellant, a 55-year-old postal employee, filed a claim for fibromyalgia, cervical spondylosis, carpal tunnel syndrome (CTS), restless leg syndrome and post-traumatic syndrome. She attributed her conditions to a July 10, 2007 incident when, after slipping and falling on a wet sign in the post office's parking lot, she was awake more than half the night in physical and emotional stress, worrying about having to start over with a new workers' compensation claim and experiencing tension in her neck, legs and arms.

In support of her claim, appellant submitted an August 21, 2007 note signed by an individual whose signature is illegible. This note reported that appellant had been treated for fibromyalgia after she suffered a fall at work, during which she apparently landed on her right wrist and lumbar spine. This note also indicated that a month after the incident appellant's fibromyalgia was active and more pain was elicited on palpation than had been previously observed.

Appellant submitted a hand-written, personal note dated February 7, 2008, in which she reported that she had been under heavy medication and was trying to get the additional paper work together but that she was severely depressed and that, between work, water therapy and sleeping 10 to 14 hours per day, she had not mentally or physically had the time to assemble the paperwork. She requested an extension.

By decision dated February 20, 2008, the Office denied appellant's claim because the medical evidence of record did not demonstrate that the claimed medical condition was related to the established work-related event.

Appellant disagreed and requested an oral hearing. A hearing was conducted on July 3, 2008 and she and her attorney were present. Appellant testified that she arrived at the post office and parked in the handicap space. As she went around the front of her car, clicking the "open" button on her key-less entry device as she walked, she began to slide. Appellant said she attempted to break her fall but landed on her buttocks; but she also alleged that she caught herself using her right hand. She testified that she attempted to tell her supervisor about the fall day, but her supervisor told her to come back after her lunch break. Appellant's husband took her to the hospital for examination and treatment. She returned to work, but also consulted with a neurosurgeon, who was also the physician she originally saw in 2001 for her fibromyalgia and a psychiatrist. Appellant testified that her neurosurgeon referred her to a psychiatrist.

Appellant submitted a July 10, 2007 unsigned report from the North Oaks Medical Center in which Dr. Jay Smith, Board-certified in emergency medicine, noted treating appellant for a fall. Dr. Smith diagnosed appellant with wrist contusion and low back pain.²

By report dated July 8, 2008, Dr. P. McLean Jackson, a radiologist, reported that a July 7, 2008 magnetic resonance imaging (MRI) scan of appellant's lumbar spine revealed mild bilateral facet arthropathy at the L3-4 region with no evidence of significant stenosis, disc bulge or herniation. The MRI scan demonstrated moderate disc space desiccation, moderate broad-based disc bulge slightly asymmetric to the right, and bilateral moderate facet arthropathy without significant spinal canal or neuroforaminal stenosis. It also demonstrated L5-S1 mild/moderate desiccation, mild broad-based disc bulge without herniation, but significant stenosis.

Appellant submitted an undated note from Dr. N. Lynn Rogers, a Board-certified neurologist, who outlined her course of treatment. In a separate report dated August 5, 2008, Dr. Rogers reported that examination revealed tenderness at the first metacarpal phalangeal joint. She also observed tenderness in appellant's lumbar paravertebral muscles with decreased range of motion. Dr. Rogers diagnosed bilateral carpal tunnel syndrome. She included a new diagnosis of left carpal tunnel syndrome; which she attributed to appellant's July 10, 2007 injury, because, since the July 2007 injury, appellant had to exclusively use her left hand to perform tasks at work. Dr. Rogers diagnosed L4-5 disc herniation, secondary to the fall of July 10, 2007.

Dr. Rogers opined that appellant's anxiety was exacerbated by the stress of trying to work with her low back pain. She reported that appellant had been assigned to sit in a 6-by-10-foot room for an entire day with occasional breaks and that this work assignment was causing increased anxiety and depression. Dr. Rogers also diagnosed appellant with degenerative disc disease at L3-4 and L5-S1, tendinitis of the right thumb, post-traumatic stress disorder, and fibromyalgia, as aggravated by the injury of July 10, 2007. She opined that, because appellant had not complained of low back pain until after the July 10, 2007 fall, the lumbar disc injury visible on the July 7, 2008 MRI scan, as well as the subsequent degenerative changes at the adjacent L3-4 and L5-S1 levels were post-traumatic in etiology, stemming from the July 10, 2007 injury.

By decision dated September 25, 2008, the Office hearing representative affirmed the Office's February 20, 2008 decision. The hearing representative found that the record did not dispute that appellant sustained a wrist contusion on July 10, 2007 during an incident at work.

² The Board notes that appellant also submitted two hand-written medical notes, date July 28 and 30, 2008, signed by an individual whose signature is illegible. This individual asserted that appellant could not work in any meaningful capacity and that input from Dr. Rogers would be helpful. As this individual does not appear to be a physician, her medical opinion is of no probative value. *See also* 5 U.S.C. § 8101(2); *see also* G.G., 58 ECAB ____ (Docket No. 06-1564, issued February 27, 2007); *Jerre R. Rinehart*, 45 ECAB 518 (1994); *Barbara J. Williams*, 40 ECAB 649 (1989); *Jan A. White*, 34 ECAB 515 (1983).

The hearing representative also found that the record did not establish that the fall resulted in the other conditions that appellant claimed.³

LEGAL PRECEDENT

An employee seeking benefits under the Federal Employees' Compensation Act⁴ has the burden of proof to establish the essential elements of his claim by the weight of the evidence,⁵ including that he sustained an injury in the performance of duty and that any specific condition or disability for work for which he claims compensation is causally related to that employment injury.⁶ As part of his burden, the employee must submit rationalized medical opinion evidence based on a complete factual and medical background showing causal relationship.⁷ The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of the analysis manifested and the medical rationale expressed in support of the physician's opinion.⁸

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on whether there is a causal relationship between the employee's diagnosed condition and the compensable employment factors. 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.⁹

ANALYSIS

Appellant filed a traumatic injury claim for fibromyalgia, cervical spondylosis, CTS, restless leg syndrome and post-traumatic syndrome. She attributed her condition to a July 10,

³ On appeal, appellant submitted additional medical evidence consisting of an October 6, 2008 medical report signed by Dr. Rogers. The Board may not consider evidence for the first time on appeal which was not before the Office at the time it issued the final decision in the case. 20 C.F.R. § 501.2(c). See *J.T.*, 59 ECAB ___ (Docket No. 07-1898, issued January 7, 2008) (holding the Board's jurisdiction is limited to reviewing the evidence that was before the Office at the time of its final decision). As this evidence was not part of the record when the Office issued either of its previous decisions, the Board may not consider it for the first time as part of appellant's appeal.

⁴ 5 U.S.C. §§ 8101-8193.

⁵ *J.P.*, 59 ECAB ___ (Docket No. 07-1159, issued November 15, 2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

⁶ *G.T.*, 59 ECAB ___ (Docket No. 07-1345, issued April 11, 2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

⁷ *G.T.*, *supra* note 6; *Nancy G. O'Meara*, 12 ECAB 67, 71 (1960).

⁸ *Jennifer Atkerson*, 55 ECAB 317, 319 (2004); *Naomi A. Lilly*, 10 ECAB 560, 573 (1959).

⁹ *I.J.*, 59 ECAB ___ (Docket No. 07-2362, issued March 11, 2008); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

2007 incident when she fell while in the employing establishment's parking lot. The hearing representative found that the record established that appellant sustained only a wrist contusion, a condition not alleged or claimed by appellant, as a result of the July 10, 2007 incident. It is appellant's burden to establish through the production of competent and probative rationalized medical opinion evidence based on a complete factual and medical background, that her conditions were caused or aggravated by the July 10, 2007 employment-related incident. The Board finds the evidence of record insufficient to meet this standard and, therefore, appellant has not met her burden of proof to establish that the alleged conditions were sustained in the performance of duty on July 10, 2007.

The relevant medical evidence of record consists of medical reports and a medical note from Drs. Rogers and Jackson. Dr. Rogers' reports and note are of limited probative value as in neither document did Dr. Rogers proffer a rationalized medical opinion concerning a causal relationship between a diagnosed condition and the identified employment-related incident. The Board has held that medical reports that lack a rationalized opinion on causal relationship are of limited probative value.¹⁰ While Dr. Rogers repeatedly opined that the medical conditions she diagnosed were related to appellant's July 10, 2007 fall in the employing establishment parking lot, her opinion was conclusory and lacked a sufficiently rationalized explanation.

Throughout her enumerated list of diagnosed conditions, Dr. Rogers at no time proffered a rationalized medical opinion that addressed how the fall of July 10, 2007 produced the conditions listed in appellant's claim. Thus, her reports and note are of limited probative value and are insufficient to satisfy appellant's burden of proof. The Board notes that appellant apparently had preexisting cervical and fibromyalgia conditions prior to this July 10, 2007 incident. The medical evidence must record a complete medical history and also explain physiologically how the July 10, 2007 incident was causative of appellant's current conditions, and why her current complaints were not simply related to the preexisting conditions. Dr. Rogers' reports do not contain this necessary medical information.

Similarly, Dr. Johnson's report is of limited probative value. Although he reported findings upon examination and a diagnosis, his report does not present a thorough review of appellant's medical history or proffer an opinion concerning the causal relationship between the diagnosed conditions and the identified July 10, 2007 employment-related incident. As previously noted, medical reports lacking an opinion on causal relationship are of limited probative value.¹¹ As Dr. Rogers' radiological report lacks an opinion concerning the causal relationship between the diagnosed medical conditions and the July 10, 2007 incident, it is of limited probative value and is insufficient to satisfy appellant's burden of proof.

The unsigned medical report from North Oaks Medical Center is of no probative medical value. The Board has held that an unsigned report with no adequate indication that it was

¹⁰ See *Mary E. Marshall*, 56 ECAB 420 (2005) (medical reports that do not contain rationale on causal relationship have little probative value). See also, *Jimmie H. Duckett*, 52 ECAB 332 (2001); *Franklin D. Haislah*, 52 ECAB 457 (2001).

¹¹ *Id.* See also, *A.D.*, 58 ECAB ____ (Docket No. 06-1183, issued November 14, 2006) (stating 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).

completed by a physician is not considered probative medical evidence.¹² Because this medical report was not signed by a physician there is no adequate indication that it was completed by Dr. Smith and, therefore, the report does not constitute probative medical evidence. Thus, this report is of no probative medical value and is insufficient to satisfy appellant's burden of proof.

As appellant has submitted no competent and probative rationalized medical evidence in support of her claim, she has not met her burden of proof to establish that she sustained an injury in the performance of duty on July 10, 2007.

CONCLUSION

The Board finds appellant has not met her burden of proof to establish that she sustained an injury in the performance of duty on July 10, 2007.

ORDER

IT IS HEREBY ORDERED THAT the September 25, 2008 decision of the Office of Workers' Compensation Program's Branch of Hearings and Review is affirmed.

Issued: September 10, 2009
Washington, DC

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

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

¹² See *D.D.*, 57 ECAB 734 (2006); *Merton J. Sills*, 39 ECAB 572, 575 (1988).