United States Department of Labor
Employees' Compensation Appeals Board

G.J., Appellant	)	
and	)	**Docket No. 11-635**
	)	**Issued: January 6, 2012**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRATION, Brecksville, 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:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On January 13, 2011 appellant, through her attorney, filed a timely appeal from a December 8, 2010 Office of Workers' Compensation Programs' (OWCP) merit decision which denied her claim for an employment-related injury. 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.[2]

ISSUE

The issue is whether appellant met her burden of proof to establish that she developed a neck and/or upper extremity condition in the performance of duty causally related to factors of her federal employment.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that following issuance of the December 8, 2010 OWCP decision, appellant submitted new evidence. The Board is precluded from reviewing evidence which was not before OWCP at the time it issued its final decision. *See* 20 C.F.R. § 501.2(c)(1).

On appeal, appellant's attorney contends that the December 8, 2010 OWCP decision is contrary to fact and law.

FACTUAL HISTORY

On November 10, 2008 appellant, then a 48-year-old medical support assistant, filed a traumatic injury claim (Form CA-1) alleging that she sustained a cervical injury with shoulder pain down her arm and hand in the performance of duty on September 8, 2008. She indicated that the cause of injury was improper desk and chair support.

By letter dated November 17, 2008, OWCP requested additional evidence to support her claim and allotted 30 days for submission.

In an October 7, 2008 report, Dr. Edward P. Horvath, a physician Board-certified in internal and occupational medicine, stated that appellant presented to the clinic with documentation that she be accommodated for left shoulder arthritis/bursitis by having her workstation modified.

In a November 17, 2008 report, Dr. Barbara Bangert, a Board-certified radiologist, reviewed a magnetic resonance imaging (MRI) scan of the cervical spine. She diagnosed mild reversal of the normal cervical lordosis at the C4-5 level with small, broad-based central disc herniation effacing the ventral thecal sac. Dr. Bangert found minimal degenerative changes in the lower cervical spine.

Appellant submitted a December 2, 2008 narrative statement describing how her injury occurred. She explained that the chair at her workstation was not adjustable and the lack of support put a strain on her wrist, elbow and shoulder. Pulling and filing x-ray film jackets as low as a few inches from the floor and several inches above her head, caused her to strain her ligament, muscle and tendon, pinch a nerve and strain her neck and shoulder.

In a December 8, 2008 statement, the employing establishment noted that its medical records revealed that appellant had left shoulder arthritis/bursitis. It controverted continuation of pay (COP) on the grounds that appellant's claim was actually an occupational disease and not a traumatic injury claim.

In a December 8, 2008 statement, appellant's supervisor indicated that he had been her supervisor since 2001. Appellant had worked in her position since 1989 which required lifting extremely heavy x-ray jackets, filing them on shelves above her head and hanging x-rays for reading purposes. The supervisor provided her and other employees in the area various chairs and furnishings to accommodate them and the workroom had been renovated in the past year. Since 2001, the department was approximately 98 percent filmless and the need for lifting had been dramatically reduced. This reduction took place over the last seven years, so the amount of lifting duties appellant had to do was reduced significantly each year. For the past year, appellant had worked upstairs in the ambulatory area, greeting patients and doing examination registration which required sitting and keyboard use but no lifting.

In a December 22, 2008 decision, OWCP adjudicated appellant's claim as one for an occupational disease claim and found that she was not entitled to COP. It requested additional factual and medical information in support of the claim and allotted 20 days for submission.

In a September 23, 2008 report, Dr. Patricia Moore, a Board-certified family medicine physician, diagnosed shoulder pain/tendinitis and advised appellant to avoid working on a high keyboard and/or desk.

In an October 10, 2008 report, Dr. Brian N. Victoroff, a Board-certified orthopedic surgeon, diagnosed cervical radiculitis. He found that appellant had pain from her trapezius down the anterior left shoulder onto the radial forearm and base of the left thumb since September 2008. Upon examination, appellant's cervical spine was flexible but in the trapezius on turning to the contralateral side she had slight pain on cervical compression and in the extended position but a negative Lhermitte sign. Dr. Victoroff indicated that her cervical and shoulder radiographs were normal. In an October 31, 2008 progress report, he reiterated his diagnosis and opined that it was most likely related to a cervical nerve root compression.

In a November 13, 2008 medical report, Dr. Nicholas U. Ahn, a Board-certified orthopedic surgeon, diagnosed mechanical neck pain with radiation down both upper extremities left greater than right with associated weakness and numbness. He opined that her symptoms and physical findings were very consistent with nerve compression of the cervical spine causing radiating radicular-type discomfort down the left upper extremity.

On November 20, 2008 Dr. Ahn indicated that appellant had an MRI scan which demonstrated a minimal bulge at C4-5. He opined that there was nothing significant for which surgery would be appropriate.

In a January 7, 2009 progress report, Dr. Moore diagnosed cervical neck arthritis with cervical disc herniation documented on a November 17, 2008 MRI scan. She opined that appellant's symptoms of cervical radiculopathy could relate to her years of work lifting and reaching above her head and that these activities definitely aggravated her current problems.

In a January 12, 2009 narrative statement, appellant stated that she was reassigned to work in the film library six or seven years ago. She was required to lift and pull 5 to 25 pounds x-ray jackets continuously everyday for three to four years, but that duty was discontinued in 2006. Appellant also pushed 50 to 100 pounds daily as the x-ray jackets were loaded onto a cart and pushed upstairs for delivery. She also worked at a countertop for seven years which strained her muscles, ligaments and tendons.

By decision dated January 23, 2009, OWCP denied the claim on the grounds that the medical evidence submitted did not establish causal relationship.

On February 9, 2009 appellant requested an oral hearing.

Appellant submitted a February 3, 2009 report by Dr. Moore, who reiterated her diagnosis and opined that years of work at a counter and keyboard and lifting and reaching above her head had definitely aggravated her neck and left shoulder pain and arm numbness.

Dr. Moore further opined that appellant's current keyboard and adjustable chair continued to aggravate her cervical, shoulder and left arm symptoms.

On May 21, 2009 an oral hearing was held before OWCP's hearing representative. Appellant testified that she worked in an awkward position at a counter from 2000 to 2007 for four to eight hours a day. She testified that her lifting and filing duties decreased in 2007. In 2008 appellant was transferred to the ambulatory area where she was not required to do any lifting and her supervisor provided a new chair that accommodated her condition. She testified that she started having symptoms in 2007 which she attributed to her work in the film library and to an unadjustable chair in the ambulatory area. OWCP's hearing representative held the record open for 30 days for the submission of additional evidence.

Appellant submitted a July 31, 2006 report by Dr. Horvath, who obtained a history of three-days of cervical pain and muscle spasm which she first noticed at work. Dr. Horvath stated that it was of gradual onset and not associated with any known trauma of incident. He reported that appellant had a similar episode a few years ago but it was not as severe. Dr. Horvath advised her to remain at work without restrictions.

By decision dated August 7, 2009, OWCP's hearing representative vacated the January 23, 2009 decision and remanded the case to the district OWCP for a *de novo* decision. She instructed OWCP to send a statement of accepted facts to her attending physician, Dr. Moore, and request a rationalized medical explanation of causal relationship.

Appellant submitted a series of surgical records from Dr. Al-Amin A. Khalil, a Board-certified anesthesiologist, who administered nerve blocks and steroids injections on January 2, 23, February 6, April 24, May 22 and June 26, 2009.

In a March 26, 2009 report, Dr. Ahn advised that appellant had some neck pain and left upper extremity symptoms. He listed his concern that she may have carpal tunnel syndrome and ordered an electromyograph (EMG) of both upper extremities. Dr. Ahn subsequently advised that the EMG's were normal. There was no evidence of cervical radiculopathy or carpal tunnel syndrome. Dr. Ahn ruled out a surgical lesion based on the negative cervical MRI scan and EMG's.

In an August 5, 2009 radiological report, Dr. Peter Young, a Board-certified radiologist, reviewed an MRI scan of the left shoulder and diagnosed mild hypertrophic degenerative changes of the acromioclavicular (AC) joint and otherwise no internal derangement.

In a September 8, 2009 work capacity evaluation, Dr. Moore diagnosed cervical pinched nerve, carpal tunnel and AC degenerative changes. She advised that appellant was able to perform her new job of patient registration with the new supportive chair physical restrictions: minimize reaching; avoid reaching above shoulder completely; and avoid prolonged repetitive wrist movements.

On September 24, 2009 OWCP referred appellant to a second opinion physician with a statement of accepted facts. In an October 26, 2009 report, Dr. Manhal A. Ghanma, a Board-certified orthopedic surgeon, diagnosed degenerative disc disease in the cervical spine. He opined that there was insufficient objective evidence to support any nerve compression in the

cervical spine or any significant abnormality in the left shoulder aside from mild AC joint arthritis. Dr. Ghanma concluded that the evidence did not support any actual injury occurred and there were no medical findings of disabling residuals. While it was possible the implicated work factors could have resulted in a labral tear which could explain some of appellant's, it did not explain all of her symptoms. Dr. Ghanma found that appellant was medically capable of performing her regular job duties without any physical restrictions. He recommended obtaining a left shoulder MRI scan arthrogram to determine whether she had a labral tear, as it could be related to overhead activity with the arm in external rotation and abduction as is often required with pulling x-ray jackets off elevated shelves. Dr. Ghanma indicated that if the MRI scan arthrogram was negative, then no further treatment would be necessary for her work complaints.

By decision dated November 16, 2009, OWCP denied appellant's claim on the grounds that the medical evidence submitted did not establish causal relationship.

On November 24, 2009 appellant, through counsel, requested an oral telephone hearing.

By decision dated March 16, 2010, OWCP's hearing representative found that the case was not in posture for a hearing. She set aside the November 16, 2009 decision and remanded the case for OWCP to authorize an MRI scan to rule out a labral tear, as recommended by Dr. Ghanma. OWCP was to request an addendum report to complete the physicians' assessment of causal relationship.

In an October 3, 2008 report, Dr. Ali D. Askari, a Board-certified rheumatologist and internist, diagnosed positive antinuclear antibody test and left shoulder pain. He indicated that the rheumatologic problem appeared to be subacromial bursitis.

In a September 8, 2009 report, Dr. Moore diagnosed left-sided acromioclavicular hypertrophic degenerative changes, cervical spine degenerative arthritis at C5-6, C6-7 and C7-T1 with cervical disc herniation at C4-5 and carpal tunnel left greater than right wrist. She opined that based upon appellant's symptoms, physical examination and medical history, all of her diagnoses were aggravated by the factors of her federal employment, including lifting, pushing, pulling x-ray files, poor wrist alignment and support. Dr. Moore indicated that the historical development and worsening of symptoms over the course of appellant's job duties supported the association of her job duties accelerating the progression of all three diagnoses.

In a November 17, 2009 report, Dr. Askari diagnosed left shoulder pain, carpal tunnel syndrome and cervical radiculopathy. On March 18, 2010 he reiterated his diagnoses.

In an April 2, 2010 radiological report, Dr. Young reiterated his diagnosis and indicated that the left shoulder MRI scan had not significantly changed compared to the prior August 5, 2009 study and revealed that the labrum was within normal limits.

On May 21, 2010 Dr. Khalil performed a left C4, C5 and C6 medical branch radiofrequency ablation.

In a June 23, 2010 addendum, Dr. Ghanma advised that appellant had minimal abnormalities on her November 17, 2008 cervical spine MRI scan and degenerative changes of the AC joint. The labrum was reported as within normal limits on her left shoulder MRI scan of

April 2, 2010. Dr. Ghanma concluded that there was insufficient evidence to support that she had degenerative disc disease of the cervical spine or left shoulder area. He opined that neither condition was caused, aggravated, accelerated or precipitated by the factors of employment implicated in the statement of accepted facts. Dr. Ghanma found insufficient evidence to support an injury based on objective findings or diagnostic test results. He stated that no futher medical treatment was necessary and that her current complaints could not be explained based on the alleged injuries or strains. Dr. Ghanma concluded that there was no evidence to support that any condition that she had was directly caused or aggravated by factors of her federal employment.

By decision dated June 29, 2010, OWCP denied appellant's claim on the grounds that the medical evidence submitted did not establish causal relationship.

On July 6, 2010 appellant, through counsel, requested an oral telephone hearing and submitted an illegible medical report dated July 22, 2010 from Dr. Askari.

In a July 27, 2010 report, Dr. Moore opined that lack of back, elbow and wrist supports caused wear and tear changes or arthritis in her AC joint and cervical arthritis and aggravated carpal tunnel problems.

In an August 31, 2010 report, Dr. Moore opined that due to appellant's nonergonomic workstation from 2001 to 2008, appellant developed worsening shoulder, acromioclavicular, neck and carpal tunnel pain. She indicated that appellant was still symptomatic and required treatment.

On October 12, 2010 an oral telephone hearing was held before OWCP's hearing representative. Appellant testified that she had cervical spondylosis and lumbar spondylosis without myelopathy. She also testified that she had abnormalities in her spine and degenerative changes in the joint of her left shoulder, but no labral tear in her left shoulder.

By decision dated December 8, 2010, the hearing representative affirmed the June 29, 2010 OWCP decision on the grounds that the medical evidence submitted did not establish causal relationship. OWCP found that Dr. Ghanma's second opinion report and subsequent addendum constituted the weight of the medical evidence and failed to support causal relationship between a neck and/or upper extremity condition and factors of appellant's federal employment.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] 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 FECA, that the claim was timely filed within the applicable time limitation period of FECA, and that an injury[4] was sustained in the performance of duty. These

[3] 5 U.S.C. §§ 8101-8193.

[4] OWCP's regulations define an occupational disease or illness as a condition produced by the work environment over a period longer than a single workday or shift. 20 C.F.R. § 10.5(q).

are the essential elements of each compensation claim, regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[5]

To establish that an injury was sustained in the performance of duty in a claim for an occupational disease claim, an employee must submit the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[6]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical 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 implicated employment factors.[7] 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.[8]

ANALYSIS

The Board finds that appellant has failed to establish that she developed a neck or upper extremity condition in the performance of duty. The evidence supports that her work was at an awkward workstation where she lifted, filed and pushed x-ray jackets from 1989 to 2007. Appellant has not established that her neck or upper extremity conditions are causally related to the implicated factors of her federal employment.

OWCP referred appellant to Dr. Ghanma for a second opinion. In an October 26, 2009 report, Dr. Ghanma reviewed the statement of accepted facts, appellant's history and prior medical records. He diagnosed degenerative disc disease in the cervical spine and opined that there was insufficient evidence to support nerve compression in the cervical spine or any significant abnormality in the left shoulder aside from mild AC joint arthritis. Pending additional diagnostic testing, Dr. Ghanma concluded that there was insufficient evidence to support injury as there were no medical findings of disabling residuals. In his June 23, 2010 addendum, he observed that appellant had minimal abnormalities on her cervical spine MRI scan dated November 17, 2008 and degenerative changes of the AC joint and a labrum within normal limits on her left shoulder MRI scan dated April 2, 2010. Dr. Ghanma concluded that the diagnostic evidence did not support that she had degenerative disc disease in the cervical spine or labral tear of the left shoulder area. He opined that neither condition was caused, aggravated,

[5] *See Ellen L. Noble*, 55 ECAB 530 (2004). *See also J.C.*, Docket No. 09-1630 (issued April 14, 2010).

[6] *Id. See also Roy L. Humphrey*, 57 ECAB 238, 241 (2005); *Ruby I. Fish*, 46 ECAB 276, 279 (1994).

[7] *See D.N.*, Docket No. 10-1762 (issued May 10, 2011).

[8] *See Victor J. Woodhams*, 41 ECAB 345 (1989). *See also D.E.*, Docket No. 07-27 (issued April 6, 2007).

accelerated or precipitated by the factors of employment implicated in the statement of accepted facts. Dr. Ghanma concluded that there was no evidence to support that any of appellant's conditions were directly caused or aggravated by factors of her federal employment. The second opinion obtained from him offered rationale negating causal relationship, represents the weight of medical evidence as it is based on an accurate history of injury and a comparison of the relevant diagnostic studies.[9]

On September 23, 2008 Dr. Moore diagnosed shoulder pain/tendinitis and advised appellant to avoid working on a high keyboard and/or desk. On January 7, 2009 she diagnosed cervical neck arthritis with cervical disc herniation and opined that appellant's symptoms of cervical radiculopathy could relate to her years of work lifting and reaching above her head and that these activities definitely aggravated her current problems. On February 3, 2009 Dr. Moore reiterated appellant's diagnosis and opined that years of work at a counter and keyboard and lifting and reaching above her head had definitely aggravated her neck and left shoulder pain and arm numbness and that appellant's current keyboard and adjustable chair continued to aggravate her cervical, shoulder and left arm symptoms. On September 8, 2009 she diagnosed left-sided AC hypertrophic degenerative changes, cervical spine degenerative arthritis at C5-6, C6-7 and C7-T1 with cervical disc herniation at C4-5 and carpal tunnel left greater than right wrist and opined that all of her diagnoses were aggravated by the factors of her federal employment, including lifting, pushing, pulling x-ray files, poor wrist alignment and support. Dr. Moore generally noted that the historical development and worsening of symptoms over the course of appellant's employment supported the association of her job duties accelerating the progression of all three diagnoses. On July 27, 2010 she opined that lack of back, elbow and wrist supports caused wear and tear changes or arthritis in her AC joint and cervical arthritis and aggravated carpal tunnel problems. On August 31, 2010 Dr. Moore opined that due to appellant's nonergonomic workstation from 2001 to 2008, appellant developed worsening shoulder, AC, neck and carpal tunnel pain. The Board has held that the mere fact that appellant's symptoms arise during a period of employment or produce symptoms revelatory of an underlying condition does not establish a causal relationship between her condition and her employment factors.[10] Although she identified factors of appellant's federal employment, Dr. Moore did not provide a rationalized medical opinion explaining how factors of appellant's federal employment, such as working in unaccommodating workstation, lifting, filing and pushing x-ray jackets, caused or aggravated her neck and/or upper extremity condition. Lacking thorough medical rationale on the issue of causal relationship, her reports are insufficient to establish that appellant sustained an employment-related injury.

On November 13, 2008 Dr. Ahn diagnosed mechanical neck pain with radiation down both upper extremities left greater than right with associated weakness and numbness. He opined that appellant's symptoms and physical findings were very consistent with nerve compression of the cervical spine causing radiating radicular-type discomfort down the left upper extremity. On November 20, 2008 Dr. Ahn indicated that an MRI scan demonstrated a minimal bulge at C4-5 and opined that there was nothing significant for which surgery would be

[9] *See W.M.*, Docket No. 09-733 (issued November 9, 2009).

[10] *See Robert G. Morris*, 48 ECAB 238, 239 (1996); *Richard B. Cissel*, 32 ECAB 1910, 1917 (1981); *William Nimitz, Jr.*, 30 ECAB 567, 570 (1979). *See also M.V.*, Docket No. 10-1169 (issued December 17, 2010).

appropriate. On March 26, 2009 he reported that appellant had some neck pain and left upper extremity symptoms. In an undated medical report, Dr. Ahn indicated that EMG's of both upper extremities were normal and there was no evidence of cervical radiculopathy or carpal tunnel syndrome. He ruled out a surgical lesion based on appellant's negative cervical MRI scan and EMG's. Although he provided a firm diagnosis, Dr. Ahn's reports do not provide rationalized medical opinion evidence explaining how her neck and/or upper extremity condition was caused or aggravated by factors of her federal employment. The medical reports from him are, therefore, insufficient to meet appellant's burden of proof.

On October 10, 2008 Dr. Victoroff diagnosed cervical radiculitis and indicated that appellant had pain from her trapezius down the anterior left shoulder onto the radial forearm and base of the left thumb since September 2008. He found that her cervical spine was flexible but in the trapezius on turning to the contralateral side she had slight pain on cervical compression and in the extended position, but also found a negative Lhermitte sign and indicated that her cervical and shoulder radiographs were normal. On October 31, 2008 Dr. Victoroff reiterated his diagnosis and opined that it was most likely related to a cervical nerve root compression. While his reports provide a firm diagnosis, they fail to provide a rationalized medical opinion explaining how appellant's neck and/or upper extremity condition was caused or aggravated by factors of her federal employment. Therefore, appellant did not meet her burden of proof to establish causal relationship.

Dr. Askari did not address the issue of causal relationship in either his October 3, 2008 or the November 17, 2009 and March 18, 2010 reports. Dr. Horvath indicated that appellant had a three-day history of cervical pain and muscle spasm of gradual onset, not associated with any known trauma of incident, and reported that she had a similar episode a few years ago but it was not as severe. He advised appellant to remain at work without restrictions. 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.[11] Therefore, appellant did not meet her burden of proof with these submissions.

Similarly, Drs. Young and Bangert provided firm diagnoses on x-ray examination. However, due to the diagnostic nature of his reports, the physician's did not address causal relationship. As such, the Board finds that they are insufficient to establish appellant's claim.

The Board finds that the weight of the medical evidence does not establish that appellant sustained an injury causally related to the implicated employment factors. Dr. Ghanma's report was sufficiently thorough, probative and well rationalized and constituted sufficient medical evidence for OWCP to rely upon in its December 8, 2010 decision. Accordingly, the Board finds that appellant did not establish a claim.

On appeal, counsel contends that the December 8, 2010 OWCP decision is contrary to fact and law. For the reasons stated above, the Board finds that counsel's argument is not substantiated.

[11] *See C.B.*, Docket No. 09-2027 (issued May 12, 2010); *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

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 failed to meet her burden of proof to establish that she developed a neck and/or upper extremity condition in the performance of duty causally related to factors of her federal employment.

ORDER

IT IS HEREBY ORDERED THAT the December 8, 2010 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: January 6, 2012
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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