

FACTUAL HISTORY

On July 18, 2012 appellant then a 60-year-old store associate, filed a CA-1, notice of traumatic injury, alleging that on July 14, 2012, he slipped on ice in a walk-in freezer at work and fell onto his back. He did not stop work.

On March 28, 2013 appellant filed a CA-2a, recurrence of disability claim. He noted that he was placed on light duty after his original injury on July 14, 2012.

By letter dated May 15, 2013, OWCP advised appellant that his claim was originally received as a simple, uncontroverted case which resulted in minimal or no time loss from work. It explained that appellant's claim was administratively handled to allow medical payments up to \$1,500.00; however, the merits of the claim had not been formally adjudicated. OWCP advised that, because he had filed a claim for recurrence of disability, his original claim would be formally adjudicated. It requested that appellant submit additional information including a comprehensive medical report from his treating physician with a reasoned explanation as to how the specific work factors or incidents identified by appellant had contributed to his claimed injury.

In a June 17, 2013 decision, OWCP denied the claim as appellant had not established a medical condition in connection with the claimed event or work factors.

On June 18, 2013 appellant requested an oral hearing which was held on September 17, 2013.

The employing establishment submitted a July 14, 2012 letter from the store director, Donald Mitchell, who noted that on July 14, 2012 he heard a loud noise in the walk-in refrigerator and saw appellant trying to get up from the floor using one hand. Mr. Mitchell indicated that appellant appeared to have fallen and was favoring his left arm and shoulder.

A February 28, 2012 magnetic resonance imaging (MRI) scan of the cervical spine showed multilevel disc bulges with narrowing of the spinal canal at C5-6, multilevel narrowing of the neural foramina with no evidence of fracture. A July 16, 2012 electromyogram (EMG) revealed evidence of acute left C5-6 radiculopathy. Appellant was treated by Dr. Robert A. Sabo, a Board-certified neurosurgeon, from July 14 to September 4, 2012, for left arm weakness after a fall at work. In a July 17, 2012 report, Dr. Sabo noted that appellant reported falling at work in November 2011 and July 14, 2012 and experienced left shoulder, neck, and left arm weakness since that time. He noted findings of marked weakness in motor strength of the left upper extremity, no atrophy, intact sensory examination, significant ataxia of tandem gait, and reflexes were equal and symmetric. Dr. Sabo diagnosed cervical spondylitic stenotic myelopathy with severe weakness of the left arm.

On June 25, 2013 appellant was treated by Dr. Laura E. Ross, an osteopath, for persistent left arm and right-sided pain after a slip and fall accident on July 14, 2012. Dr. Ross, in her report dated July 19, 2013, noted findings of limited range of motion of the left shoulder, atrophy of the girdle muscle, crepitus with range of motion of both hips, tenderness along both knees, and paravertebral muscle spasm. She diagnosed atrophy of the left shoulder with impingement

syndrome and probable rotator cuff tear, bilateral hip and knee pain. In reports dated July 22 and August 19, 2013, Dr. Ross noted that a right shoulder MRI scan revealed impingement tendinopathy, mild degenerative changes, and a partial rotator cuff tear. She diagnosed left shoulder atrophy of the girdle, glenohumeral osteoarthritis, impingement syndrome of the right shoulder, and polyarthralgias. Appellant also submitted a physical therapy record.

In a decision dated November 21, 2013, an OWCP hearing representative affirmed the June 17, 2013 decision as modified. The hearing representative noted that appellant had provided medical evidence supporting a history of injury and diagnosed condition; but the evidence was insufficient to establish a causal relationship between the diagnosed conditions and the accepted work accident.

On March 21, 2014 appellant requested reconsideration. He submitted a January 13, 2014 report from Dr. Ross who noted an EMG study revealed brachial plexopathy. Dr. Ross noted appellant's left shoulder was progressively worsening since his work injury of July 14, 2012. She noted findings of left shoulder girdle atrophy with weakness and diminished sensation in the left upper extremity. Dr. Ross diagnosed status postcervical disc pathology with left brachial plexopathy causing atrophy to the left shoulder and upper arm. She noted that appellant's atrophy and limited range of motion would prevent him from undergoing shoulder rehabilitation. Dr. Ross opined that this condition was caused by the slip and fall injury that occurred on July 14, 2012 and not by the normal aging process. In a March 28, 2014 report, she noted first treating appellant on June 25, 2013 for a work injury that occurred on July 14, 2012. Appellant reported a history of injury and subsequent limited movement in the left arm, with arthritis pain in his hips, knees and right shoulder. Dr. Ross noted that appellant had a prior injury in November 2011 when he had also slipped and fell on an icy floor. She diagnosed status postcervical disc pathology with left brachial plexopathy causing atrophy to the left shoulder and upper arm musculature, and exacerbation of degenerative joint disease of the left shoulder. Dr. Ross opined that appellant sustained the above-mentioned injuries as a direct result of the fall that occurred while he was working as a commissary worker on July 14, 2012. She advised that appellant's injuries were consistent with the traumatic injury that occurred when he slipped and fell on a slippery floor in a freezer injuring his neck and left arm. Dr. Ross noted appellant's condition was caused by the slip and fall injury that occurred on July 14, 2012 and not by the normal aging process. She noted that her opinion was made within a reasonable degree of medical probability.

In a decision dated June 19, 2014, OWCP denied modification of the November 21, 2013 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA 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 filed within the applicable time limitation of FECA, 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 is causally related to the

employment injury. These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.²

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. There are two components involved in establishing 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. Second, the employee must submit medical evidence to establish that the employment incident caused a personal injury.³

Rationalized medical opinion evidence is generally required to establish causal relationship. The opinion of the physician must be based on a complete factual and medical background, 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 claimant.⁴

ANALYSIS

It is undisputed that appellant slipped and fell on ice in a freezer while at work on July 14, 2012. However, appellant has not submitted sufficient medical evidence to establish that the diagnosed cervical disc pathology, left brachial plexopathy, atrophy of the left shoulder and upper arm, and exacerbation of degenerative joint disease of the left shoulder were causally related to his work injury on July 14, 2012.

On May 15, 2013 OWCP advised appellant of the medical evidence needed to establish his claim. Appellant did not submit a rationalized medical report from an attending physician addressing how specific employment factors may have caused or aggravated his claimed condition.

Appellant submitted reports from Dr. Ross dated January 13 and March 28, 2014 who noted first treating appellant on June 25, 2013 for the work injury that had occurred on July 14, 2012. Dr. Ross reported that on July 14, 2012 appellant slipped and fell on a slippery floor in a freezer injuring his neck and left arm, and right shoulder. She diagnosed status postcervical disc pathology with left brachial plexopathy causing atrophy to the left shoulder and upper arm musculature and exacerbation of degenerative joint disease of the left shoulder. Dr. Ross opined that appellant's injuries were consistent with the traumatic injury that occurred when he slipped and fell on a slippery floor in a freezer injuring his neck and left arm and were a direct result of the fall that occurred. Dr. Ross noted that appellant's atrophy and loss of range of motion were caused by the slip and fall injury that occurred on July 14, 2012 and not by the normal aging process. She noted her opinion was made within a reasonable degree of medical probability. Although Dr. Ross supported causal relationship, she did not provide sufficient

² *Gary J. Watling*, 52 ECAB 357 (2001).

³ *T.H.*, 59 ECAB 388 (2008).

⁴ *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

medical rationale explaining the basis of her conclusory opinion regarding the causal relationship between appellant's diagnosed conditions and the workplace fall. Dr. Ross did not explain how slipping and falling on ice would cause or aggravate the diagnosed conditions and why the cervical disc pathology with left brachial plexopathy, atrophy to the left shoulder and upper arm musculature, and exacerbation of degenerative joint disease of the left shoulder condition were not the result of nonwork-related factors such as age-related degenerative changes. The need for rationale is particularly important where Dr. Ross did not start treating appellant until almost a year after the July 14, 2012 work incident. Therefore, this evidence is insufficient to meet appellant's burden of proof.

On June 25, 2013 Dr. Ross treated appellant for left arm pain. Appellant reported slipping and falling at work on July 14, 2012 and experiencing limited movement in his left arm. She diagnosed internal derangement of the bilateral knees, atrophy of the left shoulder with impingement syndrome, advanced degenerative joint disease of the shoulder, right acromioclavicular joint osteoarthritis, and probable rotator cuff tear. However, Dr. Ross is merely repeating the history of injury as reported by appellant without providing her own opinion regarding whether appellant's condition was work related. To the extent that Dr. Ross is providing her own opinion, she failed to provide a rationalized opinion explaining the causal relationship between appellant's internal derangement of the bilateral knees, atrophy of the left shoulder with impingement syndrome, advanced degenerative joint disease of the shoulder, right acromioclavicular joint osteoarthritis and probable rotator cuff tear, and the factors of employment.⁵ Therefore, these reports are insufficient to meet appellant's burden of proof. In reports dated July 22 and August 19, 2013, Dr. Ross noted an MRI scan of the right shoulder which revealed impingement tendinopathy, mild degenerative changes, and a partial rotator cuff tear. She diagnosed left shoulder atrophy of the girdle, glenohumeral osteoarthritis, impingement syndrome of the right shoulder, and polyarthralgias. However, Dr. Ross did not provide an opinion on the causal relationship between appellant's job duties and his diagnosed left shoulder atrophy of the girdle, glenohumeral osteoarthritis, impingement syndrome of the right shoulder, and polyarthralgias. For this reason, this evidence is not sufficient to meet appellant's burden of proof.⁶

In the July 17, 2012 report, Dr. Sabo noted treating appellant for neck and left arm pain. Appellant reported falling on ice at work in November 2011 and on July 14, 2012. Dr. Sabo diagnosed cervical spondylitic stenotic myelopathy with severe weakness of the left arm. However, as noted above, he appears merely to be repeating the history of injury as reported by appellant without providing his own opinion regarding whether appellant's condition was work related. To the extent that Dr. Sabo is providing his own opinion he failed to provide a rationalized opinion explaining the causal relationship between appellant's cervical spondylitic stenotic myelopathy with severe weakness of the left arm and the factors of employment.

⁵ *Franklin D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value); *Jimmie H. Duckett*, 52 ECAB 332 (2001).

⁶ *Jaja K. Asaramo*, 55 ECAB 200 (2004) (medical evidence that does not offer any opinion regarding the cause of an employee's condition is of diminished probative value on the issue of causal relationship).

Appellant also submitted physical therapy records. However, the Board has held that documents from a physical therapist are not considered medical evidence as a physical therapist is not a physician under FECA.⁷

The remainder of the medical evidence, including a July 16, 2012 EMG, fails to provide an opinion on the causal relationship between appellant's job and his diagnosed shoulder and back injury.

An award of compensation may not be based on surmise, conjecture, or speculation. Neither the fact that appellant's condition became apparent during a period of employment nor the belief that his condition was caused, precipitated, or aggravated by his employment is sufficient to establish causal relationship. Causal relationships must be established by rationalized medical opinion evidence.⁸ Appellant failed to submit such evidence, and OWCP therefore properly denied appellant's claim for compensation.

On appeal appellant, through counsel, disagrees with OWCP's decision denying his claim for compensation and noted that he submitted sufficient evidence to establish his claim. As noted above, the medical evidence does not establish that appellant's diagnosed conditions were causally related to his employment. Reports from appellant's physicians failed to provide sufficient medical rationale explaining how appellant's diagnosed medical conditions were caused or aggravated by particular employment duties.

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 claimed conditions were causally related to his employment.

⁷ See *David P. Sawchuk*, 57 ECAB 316 (2006) (lay individuals, such as physician's assistants, nurses, and physical therapists are not competent under FECA to render a medical opinion); *Robert J. Krstyn*, 44 ECAB 227, 229 (1992).

⁸ See *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

ORDER

IT IS HEREBY ORDERED THAT the June 19, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 29, 2014
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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