

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

W.K., Appellant)

and)

TENNESSEE VALLEY AUTHORITY, WATTS)
BAR NUCLEAR PLANT, Spring City, TN,)
Employer)

Docket No. 15-1791
Issued: December 24, 2015

Appearances:

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

Case Submitted on the Record

DECISION AND ORDER

Before:

CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 31, 2015 appellant, through counsel, filed a timely appeal from a June 22, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merit decision in the case.²

ISSUE

The issue is whether appellant has met his burden of proof to establish an injury causally related to an October 13, 2012 employment incident.

¹ 5 U.S.C. § 8101 *et seq.*

² With her request for an appeal, appellant submitted additional evidence. However, the Board may not consider new evidence on appeal; *see* 20 C.F.R. § 501.2(c)(1).

FACTUAL HISTORY

On October 18, 2013 appellant then a 59-year-old nuclear electrical technician, filed a traumatic injury claim, Form CA-1, alleging that on October 13, 2012 while lifting and removing tulip housing from inside a compartment of a unit board he injured his left shoulder. He did not stop work.

By letter dated October 21, 2013, OWCP advised appellant of the type of evidence needed to establish his claim, particularly requesting that he submit a physician's reasoned opinion addressing the relationship of his claimed condition and specific employment factors.

Appellant submitted employing establishment records from Dr. Linda M. Pate, a specialist in general surgery, dated August 18, 2010 to November 14, 2011, who treated him for an eye injury and sore throat.

In a report of an alleged work injury dated October 14, 2012, a person with an illegible signature treated appellant for a left shoulder injury. Appellant reported replacing damaged bushing while holding his arms over his head which caused left shoulder pain. The healthcare provider diagnosed muscle strain. In outpatient records dated October 14 to 25, 2012, a person with an illegible signature noted a history of injury and indicated that appellant could return to work with restrictions. On October 25, 2012 appellant reported improvement of his left shoulder tenderness. He was returned to work without restrictions.

Appellant was treated by a nurse practitioner from October 2 to November 15, 2013 for a worsening left shoulder injury which occurred on October 13, 2012. The nurse noted that x-rays revealed no gross abnormalities and no fracture or dislocation.

Appellant was also treated by Dr. Fred H. Wright, a psychologist, for stress following a disagreement with his foreman on how his work injury occurred.

Dr. Debora Daniel, a Board-certified family practitioner, treated appellant on November 19, 2013 for a left shoulder injury. She indicated that appellant's left shoulder pain initially started one year ago and the precipitating event was lifting. Appellant reported that on October 13, 2012 he was lifting and trying to maneuver a large circuit board and injured his shoulder. He noted symptoms of left shoulder stiffness, crepitus, and limitations on range of motion. Dr. Daniel noted findings on examination of a mildly obese person, pain with left shoulder range of motion, intact sensation, and limited muscular strength. He diagnosed left shoulder pain.

In a decision dated November 29, 2013, OWCP denied appellant's claim for a traumatic injury as he failed to submit medical evidence containing a medical diagnosis in connection with the injury or events.

On May 20, 2014 appellant requested reconsideration. He submitted a December 5, 2013 report from Dr. Daniel who indicated that appellant's left shoulder pain initially started one year earlier and the precipitating event was lifting. Appellant noted symptoms of left shoulder stiffness, crepitus, and limitations on range of motion. Dr. Daniel reported findings that included pain with range of motion of the left shoulder and intact sensation with limited muscular strength. She diagnosed left shoulder pain. A left shoulder magnetic resonance imaging (MRI)

scan dated January 7, 2014 revealed glenohumeral degenerative arthroplasty with marginal osteophytes, labral degeneration and posterior marginal glenoid cysts, osteochondral loose body anterior to the glenoid neck, and no rotator cuff tear or acute bone abnormality.

Appellant also provided an April 22, 2014 surgical report from Dr. Jeremy Bruce, a Board-certified orthopedic surgeon, who performed a left shoulder arthroscopic biceps tenotomy, subacromial decompression, and left anterior and posterior capsular release. Dr. Bruce noted a history of appellant working for the employing establishment and having an “incidence where he was reaching overhead and had significant pain.” He diagnosed left shoulder arthritis, biceps tenosynovitis, and adhesive capsulitis. Dr. Bruce indicated that appellant might need a total shoulder replacement at some point.

In a decision dated August 12, 2014, OWCP denied appellant’s claim as modified. It noted that he submitted sufficient medical evidence to indicate diagnoses for a left shoulder condition. However, appellant’s claim was denied as the medical evidence failed to show a causal relationship between a diagnosed condition and the work activities of October 13, 2012.

On May 14, 2015 appellant requested reconsideration. He submitted reports from Dr. Daniel dated November 19 and December 5, 2013 and an MRI scan of the left shoulder dated January 7, 2014, all previously of record. Appellant submitted reports from Dr. Daniel dated August 15 and October 17, 2013 relating to preoperative clearance for bilateral upper lid blepharoplasty surgery. Dr. Daniel treated appellant in a follow-up for left shoulder pain on February 12, 2014. She indicated that appellant’s left shoulder pain started 18 months ago after lifting tulip housing at work. Dr. Daniel noted findings on examination of a mildly obese person, pain with range of motion of the left shoulder, intact sensation, and muscle strength. She diagnosed left shoulder pain.

Appellant was treated by Dr. Chad Smalley, a Board-certified orthopedist, on January 27, 2014 for left shoulder pain. He reported sustaining an injury on October 13, 2012 when he was lifting a breaker board at work. Dr. Smalley noted that appellant had decreased range of motion of the left arm, no atrophy, no effusion, minimal tenderness, and normal sensation. He diagnosed left loose body of the shoulder, left acromioclavicular osteoarthritis, left glenohumeral osteoarthritis, severe, and left shoulder pain. Dr. Smalley noted the pain generator was the glenohumeral joint osteoarthritis which was exacerbated by the work injury. He recommended a total shoulder arthroplasty. Dr. Smalley performed an injection into the left shoulder of Lidocaine.

In a decision dated June 22, 2015, OWCP denied modification of the prior 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 are 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.³

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.⁴

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.⁵

ANALYSIS

It is undisputed that on October 13, 2012 appellant lifted and removed tulip housing from inside a compartment of a unit board while at work. It is also undisputed that he has been diagnosed with left shoulder arthritis, biceps tenosynovitis, and adhesive capsulitis. However, appellant has not submitted sufficient medical evidence to establish that his diagnosed conditions were caused or aggravated by the October 13, 2012 employment incident.

Appellant submitted reports from Dr. Daniel dated November 19 and December 5, 2013 who treated him for a left shoulder injury which occurred one year ago. He reported that on October 13, 2012 he was lifting and trying to maneuver a large circuit board and injured his shoulder. Dr. Daniel noted positive findings on examination and diagnosed left shoulder pain. Similarly, on February 12, 2014 she indicated that appellant's left shoulder pain initially started 18 months ago and the precipitating event was lifting tulip housing at work. Dr. Daniel diagnosed left shoulder pain. Although Dr. Daniel generally supported a causal relationship, she did not provide sufficient medical rationale explaining the basis of her opinion regarding the causal relationship between appellant's diagnosed conditions and the workplace lifting incident. Dr. Daniel did not explain how lifting tulip housing at work would cause or aggravate the diagnosed conditions.⁶ Therefore, this evidence is insufficient to meet appellant's burden of proof.

Dr. Smalley, in a January 27, 2014 report, diagnosed left loose body of the shoulder, left acromioclavicular osteoarthritis, severe left glenohumeral osteoarthritis, and left shoulder pain. Appellant reported sustaining an injury on October 13, 2012 when he was lifting a breaker board

³ *Gary J. Watling*, 52 ECAB 357 (2001).

⁴ *T.H.*, 59 ECAB 388 (2008).

⁵ *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

⁶ See *L.D.*, Docket No. 09-1503 (issued April 15, 2010) (the fact that a condition manifests itself during a period of employment does not raise an inference that there is a causal relationship between the two).

at work. Dr. Smalley noted the pain generator was the glenohumeral joint osteoarthritis which was exacerbated by the work injury. The Board finds that, while Dr. Smalley supported causal relationship, he did not provide medical rationale explaining the basis of his conclusory opinion regarding the causal relationship between appellant's left acromioclavicular osteoarthritis, severe left glenohumeral osteoarthritis, and left shoulder pain and the factors of employment.⁷ Dr. Smalley did not explain the process by which lifting a breaker board would cause the diagnosed condition. Therefore, this report is insufficient to meet appellant's burden of proof.

Appellant submitted an operative report from Dr. Bruce dated April 22, 2014, who performed left shoulder arthroscopic biceps tenotomy, subacromial decompression, and left anterior and posterior capsular release. Dr. Bruce noted appellant's report of pain at work when reaching overhead and diagnosed left shoulder arthritis, biceps tenosynovitis, and adhesive capsulitis. However, he failed to provide a rationalized opinion regarding the causal relationship between appellant's left shoulder injury and the factors of employment believed to have caused or contributed to such condition.⁸

Other medical reports of record are of limited probative value as they fail to address causal relationship between appellant's left shoulder condition and the October 13, 2012 work incident.⁹ Also received were an October 14, 2012 report of work injury and October 14 to 25, 2012 outpatient records from providers with illegible signatures. There is no evidence that the document from the unidentified healthcare provider is from a physician. Medical documents not signed by a physician are not considered probative medical evidence and do not establish appellant's claim.¹⁰ With regard to nurse practitioner reports, the Board has held that document notes signed by a nurse are not considered medical evidence as a nurse is not considered a physician under FECA.¹¹ Thus, the treatment records from the nurse are of no probative medical value in establishing appellant's claim.

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

⁷ See *T.M.*, 60 ECAB ___ Docket No. 08-975 (issued February 6, 2009) (a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale).

⁸ *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).

⁹ *A.D.*, 58 ECAB 149 (2006) (medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

¹⁰ See *R.M.*, 59 ECAB 690 (2008); *Bradford L. Sullivan*, 33 ECAB 1568(1982) (where the Board held that a medical report may not be considered as probative medical evidence if there is no indication that the person completing the report qualifies as a "physician" as defined in FECA).

¹¹ See *David P. Sawchuk*, 57 ECAB 316 (2006) (lay individuals such as physician assistants, nurses and physical therapists are not competent to render a medical opinion under FECA); 5 U.S.C. § 8101(2) (this subsection defines a "physician" as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law).

rationalized medical opinion evidence.¹² Appellant failed to submit such evidence and OWCP therefore properly denied appellant's claim for compensation.

On appeal appellant asserted that OWCP had improperly denied his claim and believed that he submitted sufficient evidence to establish that on October 13, 2012 he sustained a left shoulder injury when lifting and removing tulip housing. As noted above, the medical evidence does not establish that appellant's diagnosed conditions were causally related to his employment. Appellant has not submitted a physician's report, based on an accurate history, which describes how work activities on October 13, 2012 caused or aggravated a left shoulder condition.

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 an injury causally related to an October 13, 2012 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the June 22, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: December 24, 2015
Washington, DC

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

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

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board

¹² See *Dennis M. Mascarenas*, 49 ECAB 215 (1997).