

FACTUAL HISTORY

On November 3, 2013 appellant, then a 69-year-old administrative support technician, filed an occupational disease claim alleging that she developed bilateral shoulder impingement and an aggravation of L4-5 spondylolisthesis due to repetitive lifting of objects weighting approximately 5 to 15 pounds, bending, twisting, stooping, and turning while on detail from October 4, 2011 through December 19, 2012. She did not stop work, but subsequently retired on November 30, 2013.

In a January 22, 2013 report, Dr. Jeffrey Carter, Board-certified in orthopedic surgery and sports medicine, noted that appellant complained of pain in both shoulders, and her back. He advised that she previously underwent rotator cuff repair in 2011. He stated that appellant attributed her back pain to lifting at work and pushing a heavy object. On physical examination, Dr. Carter found that there was no tenderness or range of motion deficits in the upper extremities. He recommended that appellant see her primary workers' compensation doctor to determine if her back complaints were employment related. In a May 2, 2013 report, Dr. Carter noted that she complained of right shoulder aching, and soreness. He advised that appellant fell on December 18, 2012 and went to the emergency room for back pain, and over time developed shoulder pain. On physical examination, Dr. Carter found tenderness of the posterior arm. He stated that appellant's pain was due to her cervical spine and that there was obvious limited range of motion in the neck and increased kyphosis. Dr. Carter opined that her cervical problems were long standing and degenerative, and were not attributable to a work problem although her symptoms may have been aggravated by a recent fall.

By letter dated December 20, 2013, OWCP notified appellant of the deficiencies in her claim and advised her of the type of evidence needed to establish her claim.

By decision dated January 22, 2014, OWCP denied appellant's claim because evidence did not establish that appellant sustained an injury in the manner alleged.

Appellant subsequently submitted documents describing the duties that she performed. She also submitted a coworker's statement describing some of her duties and documents from the employing establishment noting certain of her duties.

Appellant also submitted medical evidence. In a December 21, 2012 hospital report, Dr. Musa Khaliqi, Board-certified in internal medicine, noted that she complained of back, left shoulder, and arm pain. He noted that appellant worked as a supply technician where she did lots of lifting, pushing, and pulling. Dr. Khaliqi advised that a lumbar spine x-ray revealed mild anterolisthesis at L4-5, degenerative disc disease at L4-5, and facet joint arthrosis at L4-5, and L5-S1. He stated that a spinal cord magnetic resonance imaging (MRI) scan showed severe spinal canal stenosis at L4-5 due to a combination of anterolisthesis, broad budging of the disc osteophyte complex lateralized to the right, ligamentum flavum hypertrophy, and hypertrophic facet degenerative changes. Dr. Khaliqi offered an assessment that included acute intractable back pain. In a December 22, 2012 report, he stated that appellant was "involved in a workers' compensation issue where she had to go home from work because of the severity of the pain." Dr. Khaliqi assessed lumbar radiculopathy and low back pain in the left L5 distribution. In a

December 22, 2012 discharge report, he advised that appellant was improved and could engage in activity as tolerated but could not perform heavy lifting.

In an April 24, 2013 report, Dr. Mark Howard, a Board-certified orthopedic surgeon, noted that appellant complained of bilateral recurrent shoulder pain and pain in the hips. He advised that initially she sustained a shoulder condition due to an industrial injury but he acknowledged that he did not have the specifics of that injury. Dr. Howard further advised that appellant related that she developed lumbar pain after her job began to require more labor intensive duties. He noted that she was hospitalized in December 2012 for her back condition and she believed that it was attributable to the change and overall increase in her work activities. On physical examination of the lumbar spine Dr. Howard found that there was no tenderness or spasm and full range of motion. Upon shoulder examination, he found no clear rotator cuff weakness, mild impingement, and a mild limitation of internal rotation. Dr. Howard diagnosed bilateral shoulder impingement and L4-5 disc protrusion. He opined that, although appellant inquired about a workers' compensation claim, he did not have a clear cut basis that would support her belief that the injury was work related. In a June 19, 2013 report, Dr. Howard advised that she was experiencing lower levels of axial lumbar pain since being allowed to perform lighter work duties. He also advised that the examination was without specific pathological findings. Dr. Howard diagnosed L4-5 degenerative spondylolisthesis, and bilateral shoulder impingement.

In April 9, 2013 diagnostic reports, Dr. Joan Frisoli, Board-certified in diagnostic radiology, noted that shoulder and thoracic spine x-rays revealed a mild loss of the glenohumeral joint space, osteophyte present at the acromioclavicular joint, mild degenerative change, a trace scoliosis, and no compression fracture.

In a January 8, 2014 report, Dr. Howard advised that he treated appellant on two occasions. He noted that she had significant deformity of the lumbar segments specifically a grade 1 L4-5 degenerative spondylolisthesis with a significant associated lumbar spondylotic stenosis. Dr. Howard advised that he read a multipage document from counsel which described appellant's work history and job duties. He related that this document indicated that appellant's duties changed when the employing establishment became overstaffed with clerical personnel and she was transferred to work as a supply clerk in which she engaged in repetitive bending, twisting, reaching and carrying up to 15 pounds. Dr. Howard opined that "it does appear as if the work-related activities ... significantly contributed to her low back 'going out' and her subsequent need for medical care" since December 2012. He advised that appellant's degenerative conditions were "clearly preexisting" although she did not report that she had significant prior spinal problems or a need for medical care. Dr. Howard opined that 50 percent of appellant's past and future need for treatment is attributable to nonindustrial preexisting factors including appellant's spondylolisthesis and associated spinal stenosis and the "50 percent related to the specific workplace exposure and activities in October of 2011 through December 2012."

On April 1, 2014 appellant, through her attorney, requested reconsideration.

By decision dated July 2, 2014, OWCP found that appellant established the work duties that she believed caused her condition. However, it found that the evidence did not medically establish that her diagnosed conditions were causally related to work duties.

On appeal, appellant argued that she submitted sufficient evidence to establish her claim or, in the alternative, that OWCP had a responsibility to develop the claim.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden to establish 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, that an injury was sustained in the performance of duty as alleged and that any disabilities and/or specific conditions for which compensation is claimed are causally related to the employment injury.² 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

Whether an employee actually sustained an injury in the performance of duty begins with an analysis of whether fact of injury has been established. To establish an occupational disease claim, an employee must submit: (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.⁴

Causal relationship is a medical issue and the evidence generally required to establish causal relationship is rationalized medical opinion evidence. 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 The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested and the medical rationale expressed in support of the physician's opinion.⁶

² *Elaine Pendleton*, 40 ECAB 1143 (1989).

³ *Victor J. Woodhams*, 41 ECAB 345 (1989).

⁴ *R.H.*, 59 ECAB 382 (2008); *Ernest St. Pierre*, 51 ECAB 623 (2000).

⁵ *I.J.*, 59 ECAB 408 (2008); *supra* note 3.

⁶ *James Mack*, 43 ECAB 321 (1991).

ANALYSIS

Appellant claimed that she sustained a shoulder and back injury due to factors of her employment. There is no dispute that her job included lifting of objects weighting approximately 5 to 15 pounds. In addition, appellant's ** included bending, twisting, stooping, and turning while on ** detail. However, the medical evidence is insufficient to establish that appellant's claimed back and shoulder injury is causally related to such employment factors.

In his January 8, 2014 report, Dr. Howard advised that appellant had significant L4-5 degenerative spondylolisthesis with associated spondylotic stenosis. He noted reviewing her work duties and opined that her work-related activities significantly contributed to her low back "going out" and her subsequent need for medical care. Dr. Howard stated that 50 percent of appellant's past and future need for treatment is attributable to nonindustrial preexisting factors including her spondylolisthesis, and associated spinal stenosis, and the other 50 percent is attributable to industrial factors including the specific workplace exposure and activities in October 2011 through December 2012. Although Dr. Howard offers an opinion on causal relationship, he fails to provide any medical rationale to explain his opinion. As noted, rationalized medical opinion evidence is generally required to establish causal relationship. The need for rationale by a physician is particularly important here since the record indicates that appellant has preexisting degenerative conditions. Additionally, rationale is needed in view of Dr. Howard's April 24, 2013 report where he advised that he did not have a clear cut basis that would support appellant's belief that the injury was work related. Dr. Howard's January 8, 2014 report did not explain why he changed his opinion.

In his January 22, 2013 report, Dr. Carter noted that appellant complained of pain in both shoulders and back. He stated that she attributed her back pain to lifting at work and pushing a heavy object which he described as a work-related injury. However, Dr. Carter merely states the history as related to him by appellant. The Board has held that a physician's opinion regarding causal relationship that appears to be primarily based on appellant's own representations rather than on objective medical findings is of limited probative value.⁷ In his May 2, 2013 report, Dr. Carter noted that appellant complained of right shoulder aching and soreness. He stated that her pain was due to her cervical spine and that there was obvious limited range of motion in the neck and increased kyphosis. Dr. Carter opined that appellant's cervical problems were long standing and degenerative, and were not attributable to a work problem although her symptoms may have been aggravated by work-related factors. Although he stated that work factors may have aggravated her conditions, the Board had held that medical opinions which are speculative or equivocal are of diminished probative value.⁸ Dr. Carter did not provide any unequivocal and reasoned support to explain how any particular work duties aggravated any diagnosed condition.

⁷ See *C.G.* Docket No. 14-1430 (issued November 7, 2014).

⁸ See *S.E.*, Docket No. 08-2214 (issued May 6, 2009) (finding that opinions such as the condition is probably related, most likely related or could be related are speculative and diminish the probative value of the medical opinion); *Cecilia M. Corley*, 56 ECAB 662, 669 (2005) (finding that medical opinions which are speculative or equivocal are of diminished probative value).

In his December 21, 2012 report, Dr. Khaliqi diagnosed lumbar radiculopathy and low back pain in the left L5 distribution. He stated that appellant was “involved in a workers’ compensation issue where she had to go home from work because of the severity of the pain.” Although he states that appellant was involved in a worker’s compensation issue, Dr. Khaliqi’s statement is insufficient to discharge appellant’s burden of proof as he does not explain how any particular work factors caused or contributed to the diagnosed conditions.

Other medical reports of record are insufficient to discharge appellant’s burden of proof because they do not offer a physician’s opinion on causal relationship.⁹

Counsel argued on appeal that appellant had established her claim or, in the alternative, that OWCP failed to adequately develop the medical evidence in the record. Counsel resubmitted a 1b page brief in which he discussed the facts and law relevant to the claim. However, for the reasons listed above, the Board finds that the medical evidence did not include the necessary medical reasoning explaining the reasons why particular work duties caused or contributed to her diagnosed medical conditions.

Consequently, appellant has submitted insufficient medical evidence to establish her claim. As noted, causal relationship is a medical question that must be established by probative medical opinion from a physician. The physician must accurately describe appellant’s work duties and medically explain the pathophysiological process by which these duties would have caused or aggravated her condition.¹⁰ Because appellant has not provided such medical opinion evidence in this case, she has failed to meet her burden of proof.

Appellant may submit new evidence or argument as part of a formal 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 establish that she sustained an occupational disease caused by work-related events.

⁹ See *Jaja K. Asaramo*, 55 ECAB 200 (2004) (medical evidence that does not offer an opinion regarding the cause of an employee’s condition is of limited probative value on the issue of causal relationship).

¹⁰ *Solomon Polen*, 51 ECAB 341 (2000) (rationalized medical evidence must relate specific employment factors identified by the claimant to the claimant’s condition, with stated reasons by a physician). See also *S.T.*, Docket No. 11-237 (issued September 9, 2011).

ORDER

IT IS HEREBY ORDERED THAT the July 2, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 5, 2015
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board

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