United States Department of Labor
Employees' Compensation Appeals Board

H.N., Appellant	)	
and	)	**Docket No. 09-1838**
	)	**Issued: June 14, 2010**
DEPARTMENT OF ENERGY, SOUTHWESTERN POWER ADMINISTRATION, Springfield, MO, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On July 13, 2009 appellant filed a timely appeal from the March 30, 2009 merit decision of the Office of Workers' Compensation Programs denying his traumatic injury claim. Pursuant to 20 C.F.R. §§ 501.2 and 501.3, the Board has jurisdiction over the merits of this claim.

ISSUE

The issue is whether appellant sustained an injury while in the performance of duty on July 3, 2007.

FACTUAL HISTORY

On July 9, 2007 appellant, a 60-year-old maintenance worker foreman, filed a traumatic injury claim alleging that on July 3, 2007 he experienced chest pains and shortness of breath while installing an air conditioner. He stated that he was sprayed directly in the face with Freon, which escaped from a punctured coil.

Appellant was transported to Freeman West Hospital on the date of the alleged incident. He was treated by Dr. Chad Boutware, an emergency room physician, who reported that appellant's chest pains began while he was lifting an air conditioner at work. The record contains laboratory test results, a report of a chest x-ray, and an EKG report, all dated July 3, 2007. Dr. Boutware diagnosed "chest pains, nonspecific."

On April 21, 2008 appellant filed a Form CA2-a, alleging that he experienced a recurrence of his original July 3, 2007 injury on July 15, 2007, when he sustained a heart attack. He stated that on July 9, 2007 he had undergone foot surgery for Morton's neuroma. Appellant stopped work on July 15, 2007 and did not return until September 17, 2007.

In a letter dated May 6, 2007, the Office advised appellant that the information submitted was insufficient to establish his claim and allowed him 30 days to submit additional information, including a detailed account of the alleged injury and a physician's report, with a diagnosis and a rationalized opinion as to whether he sustained a traumatic cardiac or pulmonary condition on July 3, 2007 as a result of the alleged incident and, if so, whether he sustained a recurrence of the diagnosed condition.

The record contains a July 9, 2007 report from Dr. Robert F. Mahnken, a Board-certified orthopedic surgeon, who performed a neuroma excision of the right second interspace on that date. Dr. Mahnken's July 5, 2007 presurgical examination of appellant revealed no cardiovascular, respiratory or neurological symptoms.

The record contains a July 15, 2007 emergency room report reflecting that appellant was treated on that date by Dr. Gregory J. Kutter, Board-certified in emergency medicine, for chest pain. Appellant stated that he had experienced ongoing pressure and discomfort for about 12 days, since he was exposed to refrigerant. The record also contains reports of a July 15, 2007 EKG and chest x-ray.

Appellant submitted a July 16, 2007 report from Dr. Michael J. Roselman, a Board-certified internist, specializing in cardiovascular disease, who treated appellant for "an acute myocardial infarction in progress." He informed Dr. Roselman that his symptoms began on July 3, 2007 when he was doing some work removing an air-conditioning unit. Apparently the cooling coils were punctured and refrigerant leaked out on him. A short time later, appellant began to experience some chest discomfort, which progressively worsened, and he broke out in a profuse sweat even while resting in his air-conditioned truck. He was taken to the hospital where he was assessed. Appellant apparently showed no EMG or enzymatic abnormalities. Subsequent to the July 3, 2007 incident, he continued to experience recurring episodes of indigestion and belching, and random onset of similar chest discomfort, with radiation to the shoulder blades. Following another episode of severe discomfort on the evening of July 14, 2007, appellant went to the emergency room. His EKG at that time showed some nonspecific anterior T-wave changes, and his cardiac enzymes were negative. Appellant was given a "GI cocktail" on the suspicion he might have reflux. He was ultimately dismissed home in the early morning hours of July 15, 2007. At 6:30 a.m. on July 16, 2007, appellant developed severe and unremitting chest discomfort, with some shortness of breath and sweating and sought treatment in the emergency room. His EKG showed acute anterior injury pattern. On examination,

appellant's lungs were clear to auscultation and percussion bilaterally. Heart rate and rhythm were regular without gallops, murmurs or rubs.

Appellant provided hospital records relating to his July 16, 2007 episode. In a July 16, 2007 emergency room report, Dr. Kenneth A. Spangler, Board-certified in emergency medicine, provided a diagnosis on admission of "chest pain/post surgery." The record also contains July 16, 2007 diagnostic test results and progress notes through July 18, 2007. A July 18, 2007 operative report reflected that Dr. Roselman performed emergency percutaneous right femoral arterial puncture and sheath insertion; emergency selective left and right coronary arteriography; emergency balloon angioplasty and adjunctive dual drug eluting stent implantation of the proximal and mid left anterior descending regions; retrograde left heart catheterization and hemodynamics and left ventricular angiography.

In a May 16, 2008 statement, appellant asserted that he had no history of coronary artery disease prior to the July 3, 2007 incident. He contended that his July 16, 2007 heart attack and July 15, 2007 chest pains were directly related to his July 3, 2007 injury.

In an April 9, 2008 report, Dr. Roselman indicated that he had reviewed the medical records he was provided by appellant regarding his July 2007 hospitalizations. He stated:

> "Based on my review of these records, it is my medical opinion that the job[-] related events of July 3, 2007 were the trigger to your unstable angina of that day and subsequent days, with ultimate progression to the myocardial infarction you suffered on July 16, 2007. In hindsight, it seems that all of the chest pain episodes between those dates were cardiac related, that is, due to insufficient coronary blood flow."

Appellant submitted a report dated May 13, 2008 from Dr. Dominic M. Meldi, a Board-certified internist, who stated that he had examined appellant on March 27, 2007, at which time he had no cardiac symptoms. On July 16, 2007 appellant telephoned him with complaints of chest pains. Dr. Meldi advised him to proceed to an emergency room, where he was ultimately diagnosed with acute myocardial infarction.

In a decision dated June 6, 2008, the Office accepted that the July 3, 2007 incident had occurred as alleged, but denied appellant's claim on the grounds that the medical evidence did not demonstrate that the claimed medical condition was related to the established work-related events.

On January 2, 2009 appellant requested reconsideration.

Appellant submitted a December 23, 2008 report from Dr. Keesag A. Baron, a Board-certified internist, specializing in cardiovascular disease. Dr. Baron stated that appellant was under his care and that he had reviewed medical records in relation to the care that was given to him and the events that had transpired in 2007. He noted that appellant was asymptomatic from a cardiovascular perspective until July 3, 2007 after a job accident. Subsequent to the accident,

appellant complained of chest discomfort, which continued until he presented with a myocardial infarction and was found to have a coronary occlusion. Dr. Baron stated:

> "His symptoms began on the event that occurred on July 3, 2007 in relationship to his work. It is highly conceivable that on that date with an occupational accident he had ruptured a coronary plaque which subsequently lead to coronary insufficiency, recurring chest discomfort, eventual coronary occlusion, and myocardial infarction on July 16, 2007. This is an event that should be covered under workman's compensation."

By decision dated March 30, 2009, the Office denied modification of its June 6, 2008 decision. It found that there was no probative medical evidence which provided the diagnosis of a condition causally related to the events of July 3, 2007.

LEGAL PRECEDENT

The Federal Employees' Compensation Act provides for payment of compensation for disability or death of an employee resulting from personal injury sustained while in the performance of duty.[1] The phrase "sustained while in the performance of duty" is regarded as the equivalent of the coverage formula commonly found in workers' compensation laws, namely, arising out of and in the course of employment.[2]

An employee seeking benefits under the Act has the burden of proof to establish the essential elements of his claim, including the fact that the individual is an employee of the United States within the meaning of the Act, that the claim was timely filed within the applicable time limitation period of the Act, that an injury was sustained in the performance of duty as alleged, and that any disability or specific condition for which compensation is claimed is causally related to the employment injury.[3] When an employee claims that he sustained a traumatic injury in the performance of duty, he must establish the fact of injury, consisting of two components, which must be considered in conjunction with one another. The first is whether the employee actually experienced the incident that is alleged to have occurred at the time, place and in the manner alleged. The second is whether the employment incident caused a personal injury, and generally this can be established only by medical evidence.[4]

The claimant has the burden of establishing by the weight of reliable, probative and substantial evidence that the condition for which compensation is sought is causally related to a

[1] 5 U.S.C. § 8102(a).

[2] This construction makes the statute effective in those situations generally recognized as properly within the scope of workers' compensation law. *Charles E. McAndrews*, 55 ECAB 711 (2004); *see also Bernard D. Blum*, 1 ECAB 1 (1947).

[3] *Robert Broome*, 55 ECAB 339 (2004).

[4] *Deborah L. Beatty*, 54 ECAB 340 (2003). *See also Tracey P. Spillane*, 54 ECAB 608 (2003); *Betty J. Smith*, 54 ECAB 174 (2002). The term injury as defined by the Act, refers to a disease proximately caused by the employment. 5 U.S.C. § 8101 (5). *See* 20 C.F.R. § 10.5(q)(ee).

specific employment incident or to specific conditions of employment.[5] An award of compensation may not be based on appellant's belief of causal relationship.[6] Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish a causal relationship.[7] Simple exposure to a workplace hazard does not constitute a work-related injury entitling an employee to medical treatment under the Act.[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 evidence that includes a physician's rationalized opinion on whether there is a causal relationship between the claimant's diagnosed condition and the established incident or factor of employment. The opinion must be based on a complete factual and medical background of the claimant, 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 established incident or factor of employment.[9]

ANALYSIS

The Office accepted that appellant was a federal employee, that he timely filed his claim for compensation benefits and that the July 3, 2007 workplace incident occurred as alleged. The Board finds, however, that appellant has not submitted sufficient medical evidence to establish that the incident caused or aggravated a diagnosed medical condition.

Contemporaneous medical evidence includes a July 3, 2007 report from Dr. Boutware, who diagnosed "chest pains, nonspecific" and stated that appellant's chest pains began while he was lifting an air conditioner at work. As Dr. Boutware did not provide a specific diagnosis[10] or an opinion as to the cause of appellant's condition, his report is of limited probative value.[11] July 3 and 15, 2007 emergency room records, including laboratory test results, a report of a chest x-ray, and EKG reports, which do not contain an opinion on causal relationship, also lack probative value and are insufficient to establish appellant's claim. July 15 and 16, 2007 emergency room reports reflected appellant's complaints of chest pain, which he attributed to

[5] *Katherine J. Friday*, 47 ECAB 591, 594 (1996).

[6] *Dennis M. Mascarenas*, 49 ECAB 215, 218 (1997).

[7] *Id.*

[8] 20 C.F.R. § 10.303(a).

[9] *John W. Montoya*, 54 ECAB 306 (2003).

[10] A physician's mere diagnosis of pain, without more by way of an explanation, does not constitute a basis for payment of compensation. *Robert Broome*, *supra* note 3.

[11] Medical evidence which does not offer an opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship. *A.D.*, 58 ECAB 149 (2006); *Michael E. Smith*, 50 ECAB 313 (1999).

exposure to refrigerant on July 3, 2007. As these reports lack a specific diagnosis or an opinion as to the cause of appellant's condition, they, too, are of limited probative value.

In his July 16, 2007 report, Dr. Roselman diagnosed an "acute myocardial infarction in progress." He provided an account of appellant's symptoms, as described by his patient, beginning with the July 3, 2007 incident. Although Dr. Roselman's report establishes that appellant sustained a myocardial infarction, it does not contain an opinion as to the cause of the heart attack, which occurred nearly two weeks after his Freon exposure. Therefore, it is of diminished probative value. Similarly, Dr. Roselman's July 18, 2007 operative report, which does not contain an opinion on causal relationship, is of minimal probative value.

On April 9, 2008 Dr. Roselman opined that the July 3, 2007 incident triggered appellant's "unstable angina of that day and subsequent days, with ultimate progression to the myocardial infarction [he] suffered on July 16, 2007." He stated that in hindsight, it seemed that all of the chest pain episodes between those dates were cardiac related. Dr. Roselman's report did not include examination findings. His opinion was based only on a review of the medical records provided by appellant and was not supported by medical rationale explaining the nature of the relationship between his diagnosed condition and the July 3, 2007 incident.[12] Dr. Roselman did not explain the process by which appellant's exposure to Freon on July 3, 2007 would have led to his myocardial infarction; his vague reference to appellant's "unstable angina" or his speculation that all of appellant's chest pain episodes were cardiac related. For all of these reasons, his report is of limited probative value and insufficient to establish appellant's claim.

On December 23, 2008 Dr. Baron stated that it was "highly conceivable" that appellant had ruptured a coronary plaque on July 3, 2007, which subsequently lead to coronary insufficiency, recurring chest discomfort, eventual coronary occlusion and myocardial infarction on July 16, 2007. The only rationale provided was the fact that appellant's symptoms began on July 3, 2007 and continued until he presented with a myocardial infarction and was found to have a coronary occlusion. Dr. Baron's speculative opinion[13] is not based on a complete factual and medical background, and is not supported by medical rationale explaining the nature of the relationship between a diagnosed condition and the July 3, 2007 incident. Therefore it is of diminished probative value.[14]

The remaining medical evidence of record includes a July 9, 2007 report from Dr. Mahnken, who performed foot surgery on that date, and a May 13, 2008 report from Dr. Meldi, who stated that he had examined appellant on March 27, 2007, at which time he had no cardiac symptoms. As neither report contains an opinion as to whether appellant sustained an injury as a result of the July 3, 2007 work incident, they are of limited probative value.

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[12] *John W. Montoya*, *supra* note 9.

[13] *See Kathy Kelley*, 55 ECAB 206 (2004) (the Board has held that opinions such as, "the implant may have ruptured "and "the condition is probably related," are speculative and diminish the probative value of the medical opinion).

[14] Medical conclusions unsupported by rationale are of little probative value. *Willa M. Frazier*, 55 ECAB 379 (2004).

Appellant expressed his belief that his heart attack and concomitant pain and discomfort resulted from the accepted employment incident. The Board has held that the mere 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.[15] Neither the fact that the condition became apparent during a period of employment, nor the belief that the condition was caused or aggravated by employment factors or incidents, is sufficient to establish causal relationship.[16] Causal relationship must be substantiated by reasoned medical opinion evidence, which it is appellant's responsibility to submit. Therefore, appellant's belief that his condition was caused by the work-related incident is not determinative.

The Office advised appellant that it was his responsibility to provide a comprehensive medical report which described her symptoms, test results, diagnosis, treatment and the doctor's opinion, with medical reasons, on the cause of her condition. Appellant failed to submit appropriate medical documentation in response to the Office's request. As there is no probative, rationalized medical evidence addressing how his claimed condition was caused or aggravated by his employment, appellant has not met his burden of proof to establish that he sustained an injury in the performance of duty causally related to the accepted incident.

CONCLUSION

The Board finds that appellant has failed to meet his burden of proof to establish that he sustained a traumatic injury in the performance of duty on July 3, 2007.

[15] *See Joe T. Williams*, 44 ECAB 518, 521 (1993).

[16] *Id.*

ORDER

IT IS HEREBY ORDERED THAT the March 30, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 14, 2010
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