

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

P.K., Appellant

and

**DEPARTMENT OF THE ARMY, ARMY
NATIONAL GUARD, Columbus, OH, Employer**

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**Docket No. 11-1296
Issued: March 13, 2012**

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:

RICHARD J. DASCHBACH, Chief Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On May 2, 2011 appellant filed a timely appeal from a February 3, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP) denying his traumatic injury claim. 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 merits of this case.²

ISSUE

The issue is whether appellant met his burden of proof to establish that he sustained a cardiac condition in the performance of duty on November 23, 2010.

¹ 5 U.S.C. § 8101 *et seq.*

² The Board notes that appellant submitted additional evidence after OWCP rendered its February 3, 2011 decision. The Board's jurisdiction is limited to reviewing the evidence that was before OWCP at the time of its final decision. Therefore, this additional evidence cannot be considered by the Board. 20 C.F.R. § 510.2(c)(1); *Dennis E. Maddy*, 47 ECAB 259 (1995); *James C. Campbell*, 5 ECAB 35, 36 n.2 (1952). Appellant may submit this evidence to OWCP, together with a formal request for reconsideration, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. § 10.606(b)(2).

FACTUAL HISTORY

On December 20, 2010 appellant, then a 47-year-old aircraft mechanic, filed a traumatic injury claim (Form CA-1) alleging that on November 23, 2010 he sustained a heart attack when he experienced chest pains while walking from the flight line to the hangar after grounding aircraft. A witness to the incident stated that appellant complained of chest pain when walking from the flight line to the hangar. Appellant received medical care and stopped work that same date. He notified his supervisor on December 20, 2010.

By letter dated December 28, 2010, OWCP informed appellant that the evidence of record was insufficient to support his claim. Appellant was advised of the medical and factual evidence needed and was directed to submit it within 30 days.

In a January 21, 2011 narrative statement, appellant reported that on November 23, 2010 at 2:00 p.m. he was moving an aircraft to the flight line area and disconnecting a tow bar when he experienced tightness in his chest and upper back. He stated that his cardiologist advised that the mental stress and physical requirements of his employment, such as climbing, lifting and operating in confined areas with extreme temperatures, played a major role in causing his heart attack. Appellant previously suffered a heart attack in July 2008 from which he made a full recovery. He stated that he did not have any prior symptoms leading up to his heart attack on November 23, 2010.

In reports dated December 7, 2009 to August 11, 2010, Dr. Amjad Iqbal, Board-certified in cardiovascular disease, diagnosed appellant with coronary artery disease, hyperlipidemia and mild to moderate degree of inferior ischemia.

A November 23, 2010 radiology examination, by Dr. William Murphy, a Board-certified diagnostic radiologist, noted that appellant's chest images showed that the heart appeared normal in size with no acute infiltrates or congestion.

In a November 25, 2010 report, Dr. A. El Ghamry Sabe, a treating physician, stated that appellant experienced chest pain over the last three days which had resolved with sublingual nitroglycerin. Appellant was admitted to the emergency room on November 25, 2010 after he woke up at 12:30 a.m. with retrosternal chest pain that radiated to his neck and jaw which was not resolved by nitroglycerin. Dr. Sabe noted that appellant had a history of coronary artery disease and an inferior myocardial infarction on July 26, 2008 which resulted in an emergency cardiac catheterization and angioplasty of the totally occluded right coronary artery. Appellant also experienced recurrent chest pain in December 2009. Dr. Sabe performed a left cardiac catheterization, stent to the left anterior descending artery and placement of an intra-aortic balloon pump. He diagnosed acute anterior myocardial infarction and single vessel occlusive coronary artery disease.

In a November 25, 2010 electrocardiogram (ECG) report, Dr. Sabe noted sinus bradycardia and segment (ST) elevation. He reported that appellant's ECG was abnormal when compared with his November 23, 2010 ECG and that significant changes had occurred.

In a November 25, 2010 medical report, Dr. Jody Wozniak, a physician of osteopathic medicine, reported that appellant was admitted to the emergency room with a history of coronary artery disease and myocardial infarction. She noted a past surgical history of right and left knee arthroscopy and cardiac cath with angioplasty done in July 2008. Dr. Wozniak diagnosed acute ST elevated myocardial infarction.

In a November 28, 2010 medical report, Dr. Joseph Surmitis, Board-certified in internal medicine, reported that appellant was admitted to the emergency room on November 25, 2010 with a history of right coronary artery stenting, anterior wall myocardial infarction and hypercholesterolemia. He noted that appellant quit smoking two years ago. Dr. Surmitis diagnosed anterior wall myocardial infarction, hypercholesterolemia, bare metal stenting of the mid left anterior descending, 60 percent residual right coronary artery stenosis, cardiomyopathy and remote tobaccoism. He stated that appellant could return to work on January 3, 2011.

In a November 30, 2010 progress note, Dr. Iqbal reported that appellant had markedly aggressive coronary artery disease and mild hyperlipidemia.

On January 3, 2011 appellant submitted a claim for compensation Form CA-7 documenting leave buyback for the period November 25 to December 30, 2010.

In a January 5, 2011 attending physician's report (Form CA-20), Dr. Iqbal reported that appellant presented with angio symptoms, myocardial infarction and coronary artery disease. He checked the box marked "yes" when asked if he believed that appellant's condition was caused or aggravated by his employment activity and noted that the condition was caused by stress and physical labor. Dr. Iqbal further stated that cardiac episodes can be exacerbated by stress and physical labor and that he expected long-term cardiac disease as a result of appellant's condition. He noted that appellant was totally disabled from November 23, 2010 to January 3, 2011 and stated that he had been treating appellant since July 26, 2008.

In a January 5, 2011 Duty Status Report (Form CA-17), Dr. Iqbal reported that appellant experienced chest pain, shortness of breath and a heart attack after he ground a moving aircraft. He diagnosed progressive coronary disease.

By decision dated February 3, 2011, OWCP denied appellant's claim finding that the medical evidence did not demonstrate that the injury was related to the established November 23, 2010 employment incident.

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; that an injury was sustained while in the performance of duty as alleged and that any disability or specific condition for which compensation is claimed are causally related to the

employment injury.³ These are the essential elements of each and every compensation claim regardless of whether the claim is predicated on a traumatic injury or occupational disease.⁴

In order to determine whether an employee actually sustained an injury in the performance of duty, OWCP begins with an analysis of whether fact of injury has been established. Generally, fact of injury consists of two components which must be considered in conjunction with one another. The first component to be established is that the employee actually experienced the employment incident which is alleged to have occurred.⁵ The second component is whether the employment incident caused a personal injury and generally can be established only by medical evidence.

To establish a causal relationship between the condition, as well as any attendant disability claimed and the employment event or incident, the employee must submit rationalized medical opinion evidence based on a complete factual and medical background, supporting such a causal relationship.⁶ The opinion of the physician 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 specific employment factors identified by the claimant. This medical opinion must include an accurate history of the employee's employment injury and must explain how the condition is related to the injury. 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.⁷

ANALYSIS

OWCP accepted that the November 23, 2010 incident occurred as alleged. The issue is whether appellant established that the incident caused a cardiac condition. After careful consideration, the Board finds that he did not submit sufficient medical evidence to support that his cardiac condition is causally related to the November 23, 2010 employment incident.⁸

Appellant submitted medical reports from Dr. Iqbal dated December 7, 2009 to August 11, 2010, which diagnosed coronary artery disease, hyperlipidemia and mild to moderate degree of inferior ischemia. These medical reports are of no probative value in establishing causation because they predate the November 23, 2010 employment incident. They only show appellant's preexisting cardiac condition.

³ Gary J. Watling, 52 ECAB 278 (2001); Elaine Pendleton, 40 ECAB 1143, 1154 (1989).

⁴ Michael E. Smith, 50 ECAB 313 (1999).

⁵ Elaine Pendleton *supra* note 3 at 1143 (1989).

⁶ See 20 C.F.R. § 10.110(a); John M. Tornello, 35 ECAB 234 (1983).

⁷ James Mack, 43 ECAB 321 (1991).

⁸ See Robert Broome, 55 ECAB 339 (2004).

In a November 30, 2010 progress note, Dr. Iqbal reported that appellant had markedly aggressive coronary artery disease and mild hyperlipidemia. In a January 5, 2011 attending physician's report and duty status report, he reported that appellant experienced chest pain, shortness of breath and a heart attack while walking to the hangar. Dr. Iqbal diagnosed angio symptoms, myocardial infarction and coronary artery disease. He checked the box marked "yes" when asked if he believed that appellant's condition was caused or aggravated by his employment activity and noted that the condition was caused by stress and physical labor. Dr. Iqbal further stated that cardiac episodes can be exacerbated by stress and physical labor and that he expected long-term cardiac disease as a result of appellant's condition.

The Board finds that the opinion of Dr. Iqbal is not well rationalized. Dr. Iqbal did not provide a detailed history of the November 23, 2010 employment incident and merely repeated appellant's factual assertions. While his reports provide a medical history of preexisting coronary artery disease, he failed to adequately explain how the November 23, 2010 employment incident caused or aggravated appellant's cardiac condition. Though Dr. Iqbal concluded that causal connection exists between appellant's injury and his job duties, his reports provide no support for that conclusion. He only generally stated that stress and physical labor were the cause of appellant's condition. Dr. Iqbal failed to specifically describe what kind of physical labor and stress appellant engaged in on November 23, 2010 and how this caused or aggravated his cardiac condition. His assertion that cardiac episodes can be exacerbated by stress and physical labor is speculative in nature and of limited probative value.⁹ Medical reports without adequate rationale on causal relationship are of diminished probative value and do not meet an employee's burden of proof.¹⁰ The opinion of a physician supporting causal relationship must rest on a complete factual and medical background supported by affirmative evidence, address the specific factual and medical evidence of record and provide medical rationale explaining the relationship between the diagnosed condition and the established incident or factor of employment.¹¹ Dr. Iqbal's reports do not meet that standard and are insufficient to meet appellant's burden of proof.

In a November 23, 2010 radiology examination, Dr. Murphy reported that appellant's chest images showed that the heart appeared normal in size with no acute infiltrates or congestion. The Board finds this medical evidence to be of little probative value. Appellant alleges that his cardiac condition occurred on November 23, 2010 while in the performance of duty. Dr. Murphy's report, however, states that appellant's chest x-ray appeared normal on that date and thus provides no diagnoses that can be causally connected to the November 23, 2010 employment incident.

The remaining medical evidence of record is also insufficient to establish causal relationship. In a November 25, 2010 medical report, Dr. Sabe reported that appellant was admitted to the emergency room that same date when he woke with retrosternal chest pain. He noted that appellant had experienced chest pain over the last three days and that his ECG was

⁹ *S.W.*, Docket 08-2538 (issued May 21, 2009).

¹⁰ *Ceferino L. Gonzales*, 32 ECAB 1591 (1981).

¹¹ *See Lee R. Haywood*, 48 ECAB 145 (1996).

abnormal and showed significant changes when compared to his November 23, 2010 ECG. Dr. Sabe noted a history of coronary artery disease, an inferior myocardial infarction on July 26, 2008 with an emergency cardiac catheterization and angioplasty of the totally occluded right coronary artery. He diagnosed acute anterior myocardial infarction and single vessel occlusive coronary artery disease. In a November 25, 2010 medical report, Dr. Wozniak reported that appellant was admitted to the emergency room with a history of coronary artery disease and myocardial infarction. She diagnosed acute ST elevated myocardial infarction. In a November 28, 2010 medical report, Dr. Surmitis diagnosed anterior wall myocardial infarction, hypercholesterolemia, bare metal stenting of the mid left anterior descending, 60 percent residual right coronary artery stenosis, cardiomyopathy and remote tobaccoism.

While the above medical records address appellant's treatment and injury, the physicians failed to state any opinion on causal relationship between his cardiac condition and the November 23, 2010 employment incident. Appellant's physicians provided a detailed history of coronary artery disease and myocardial infarction but did not explain how appellant's condition was caused or aggravated by the employment incident. Further, none of appellant's physician's specifically stated that his coronary artery disease or myocardial infarction occurred on November 23, 2010. Appellant reported chest pain on that date but that, by itself, is not a medical diagnosis. While Dr. Sabe addressed a November 23, 2010 ECG report, the record before the Board does not contain this report or any other medical evidence establishing a cardiac condition from the date of the employment incident. 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.¹² Without medical reasoning explaining how the accepted employment incident caused his cardiac condition, the reports are not sufficient to meet appellant's burden of proof.¹³

On appeal, appellant contends that the mental stress and physical requirements of his employment caused his cardiac condition on November 23, 2010. His honest belief that work caused his medical problem is not in question. But that belief, however, sincerely held, does not constitute the medical evidence necessary to establish causal relationship. In the instant case, the record is without rationalized medical evidence establishing that the diagnosed medical condition is causally related to the accepted November 23, 2010 employment incident.

Evidence submitted by appellant after the final decision cannot be considered by the Board. As previously noted, the Board's jurisdiction is limited to reviewing the evidence that was before OWCP at the time of its decision.¹⁴ Appellant may submit additional evidence, together with a written request for reconsideration, to OWCP within one year of the Board's merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.606 and 10.607.

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

¹³ *C.B.*, Docket No. 08-1583 (issued December 9, 2008).

¹⁴ 20 C.F.R. § 501.2(c)(1).

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he sustained coronary artery disease and myocardial infarction on November 23, 2010 in the performance of duty, as alleged.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated February 3, 2011 is affirmed.

Issued: March 13, 2012
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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