

ISSUE

The issue is whether appellant's neck and shoulder conditions are employment related.

FACTUAL HISTORY

Appellant, a 53-year-old registered nurse, has an accepted claim for aggravation of displaced lumbar intervertebral disc, which arose on or about September 4, 2001.³ OWCP authorized a December 13, 2006 discectomy and interbody fusion at L5-S1.⁴ Following surgery, it placed appellant on the periodic compensation rolls. Appellant received wage-loss compensation for temporary total disability for approximately four and a half years.⁵

When appellant initially filed her claim in October 2005, she reported having injured both her cervical and lumbar spine. She submitted an August 3, 2005 cervical spine magnetic resonance imaging (MRI) scan that revealed disc herniations at C3-4 and C5-6, and a disc bulge at C4-5. OWCP's January 4, 2006 acceptance was for appellant's lumbar condition, which was consistent with the then-contemporaneous medical evidence that primarily focused on her lumbar and lower extremity complaints. The majority of the medical evidence received after the initial acceptance continued to focus on her preoperative and postoperative lumbar complaints. However, the record also included several reports and diagnostic studies that referenced appellant's cervical and upper extremity complaints.

Dr. Frank P. Cammisa Jr., a Board-certified orthopedic surgeon, examined appellant on August 7, 2006. He was consulted regarding the need for lumbar surgery, but noted at the time that she also complained of neck and right arm pain. Dr. Cammisa reviewed the August 3, 2005 cervical MRI scan, which he stated was of "poor quality" and did not show any specific abnormalities. His diagnoses included cervicgia (neck pain) without evidence of myelopathy or radiculopathy. Dr. Cammisa advised that appellant should be followed with respect to her cervical spine, but did not otherwise address whether her neck and right arm pain was causally related to her nursing duties.

Following appellant's lumbar surgery on December 13, 2006 she continued to complain of lumbar pain and radicular symptoms. In March 2007, her surgeon referred her for a neurophysiologic evaluation. Appellant came under the care of Dr. Kiril Kiproviski, a Board-certified neurologist with a subspecialty in clinical neurophysiology, who initially examined her on March 2, 2007. She complained of lower back pain, right gluteal pain and burning pain in the right lower extremity. There was no mention of cervical or upper extremity complaints. Dr. Kiproviski believed appellant's right leg complaints were suggestive of lumbosacral radiculopathy.

³ Appellant attributed her injury to "a lot of ... lifting and repositioning" of patients.

⁴ Dr. Frank J. Schwab, a Board-certified orthopedic surgeon, performed the December 13, 2006 surgical procedure. He initially examined appellant on November 29, 2006.

⁵ As previously indicated, *supra* note 2, OWCP terminated appellant's compensation benefits effective May 17, 2011.

On January 10, 2008 Dr. Salvatore J. Corso, a Board-certified orthopedic surgeon, examined appellant at OWCP's request. Appellant's complaints included "discomfort in her neck." Dr. Corso's examination, however, focused on her thoracolumbar spine and lower extremity complaints. He did not provide any findings or a specific diagnosis relative to her cervical complaints.

In a follow-up report dated April 4, 2008, Dr. Schwab noted that appellant had been increasingly troubled by neck pain, "which she attributes back to work-related injuries in the hospital as a nurse." Dr. Schwab stated that over the past year the focus had been on her lower back, which seemed to be stabilized under Dr. Kiprovski's care, but she had recently been troubled by increasing neck discomfort with radiation to the left scapula. Appellant denied radiation to the upper extremities, weakness, numbness or tingling. Dr. Schwab recommended a cervical MRI scan. He noted that appellant's cervical treatment should be covered under her workers' compensation claim because she attributed her symptoms to work-related incidents.

An April 4, 2008 x-ray showed reversal of the normal cervical lordosis with mild degenerative change at C4-5 and C5-6. A May 7, 2008 cervical MRI scan revealed a disc herniation at C3-4, broad-based disc protrusions at C4-5 and C5-6 and reversal of the normal cervical lordosis.

In a follow-up visit on July 25, 2008, Dr. Schwab reviewed appellant's recent cervical MRI scan, which he found revealed small disc bulges most notably at C3-4. Appellant reported persistent shoulder pain. On physical examination there was good shoulder range of motion, but pain at the end of ranges of motion and tenderness over the posterior joint space and over the scapula. Dr. Schwab recommended that appellant see a shoulder specialist.

Appellant underwent an OWCP-directed examination on January 28, 2009. Dr. Stanley Soren, a Board-certified orthopedic surgeon, noted complaints of pain in her neck radiating to her fingers, which she attributed to the September 4, 2001 lifting incident. On physical examination of the cervical spine, he noted that it was midline and there was no torticollis or spasm. Dr. Soren also noted there was barely trace tenderness in the right and left paracervical area. He reported a normal neurological examination of the upper extremities. Dr. Soren also indicated that there was good shoulder girdle strength bilaterally and full abduction of both arms. His examination focused primarily on appellant's lumbar condition and he did not offer a specific diagnosis relative to her cervical or upper extremity complaints.

Dr. Saumyajit Datta, a Board-certified family practitioner with a subspecialty in geriatric medicine, initially examined appellant on September 18, 2009 for lower back pain. No mention was made of any cervical or right shoulder complaints. When appellant returned on November 10, 2009, she complained of back pain, bilateral shoulder pain and neck pain. Dr. Datta also referred her to a pain specialist.

Dr. Clarence D. Washington, a Board-certified neurologist, examined appellant on November 3, 2009. With respect to her cervical spine, he diagnosed chronic cervical pain syndrome and chronic cervical degenerative disc disease with radiculopathy involving the upper extremities. Dr. Washington noted a history of chronic cervical and lumbosacral problems dating back to 2001 when appellant reportedly injured her back as well as her neck and arms

working as a nurse. He noted that she attributed all of her problems to the accumulated effects of lifting, pulling and pushing. Dr. Washington also noted that recent electrodiagnostic studies revealed evidence of mild bilateral ulnar neuropathy, but no evidence of cervical radiculopathy.

Dr. Matthew R. Peterson, a Board-certified anesthesiologist with a subspecialty in pain medicine, saw appellant on December 14, 2009.⁶ With respect to appellant's neck pain, he noted that the location was posterior and it radiated to both shoulders. Dr. Peterson reported that the initial onset was more than five years prior, and there was "no obvious precipitating event or injury." He also noted a history of cervical degenerative disc disease dating back to 2005 as demonstrated by MRI scan findings. Dr. Peterson did not provide a more definitive diagnosis than neck pain and recommended another cervical MRI scan.

A December 23, 2009 cervical MRI scan revealed borderline spinal canal stenosis at C3-4, C4-5 and C5-6 resulting from a small focal central disc protrusion at C3-4 and diffuse disc bulging at C4-5 and C5-6. There was also borderline/mild neural foraminal narrowing at C4-5 and C5-6.

Dr. Peterson saw appellant for a follow-up examination on March 16, 2011. Appellant complained of low back and neck pain, however, her neck pain was reportedly "getting much worse." Dr. Petersen still had not seen her latest cervical MRI scan from December 2009. He noted appellant's history of cervical degenerative disc disease based on her 2005 cervical MRI scan. Dr. Peterson diagnosed neck pain and cervical disc degeneration. With respect to appellant's cervical complaints, he recommended physical therapy.

On March 23, 2011 appellant sought approval from OWCP for treatment of her neck and shoulder pain. She initially telephoned it and then followed up with a letter confirming her conversation. Appellant claimed that her neck and shoulder pain resulted from years of "patient pulling, pushing and lifting...." She also noted that priority had been placed on her lower back while her neck and shoulder pain gradually worsened. OWCP advised appellant of the need to submit medical evidence in support of the acceptance of these additional conditions.

In an April 13, 2011 report, Dr. Schwab noted that appellant was under his care for neck, shoulder and low back pain. He stated that he initially examined her on November 29, 2006 for complaints of back pain that had started several years prior. Appellant's chief complaint at the time was her lumbosacral area. Dr. Schwab further noted that she had undergone surgery on December 13, 2006 and following stabilization of her lumbar spine, he then focused on her increasing neck discomfort, which radiated to her left scapula. He also noted that a cervical MRI scan showed disc herniations at C3-4 and C5-6. Dr. Schwab indicated that he had last seen appellant on July 28, 2008.

By decision dated April 28, 2011, OWCP denied appellant's claim for her neck and shoulder conditions. Appellant failed to establish that the claimed conditions were causally related to her September 4, 2001 employment injury.

⁶ Dr. Datta referred appellant to Dr. Peterson.

LEGAL PRECEDENT

A claimant seeking benefits under FECA has the burden of establishing the essential elements of her claim by the weight of the reliable, probative and substantial evidence, including that an injury was sustained in the performance of duty as alleged and that any specific condition or disability claimed is causally related to the employment injury.⁷

To establish that an injury was sustained in the performance of duty, a claimant must submit: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the diagnosed condition is causally related to the identified employment factors.⁸

ANALYSIS

OWCP accepted appellant's claim for aggravation of displaced lumbar intervertebral disc and authorized surgical intervention at L5-S1. Appellant has been off work since her December 13, 2006 lumbar surgery. She argued that OWCP should have also accepted her neck and shoulder conditions as employment related. Where appellant claims that a condition not accepted or approved by OWCP was due to her employment injury, she bears the burden of proof to establish that the condition is causally related to the employment injury.⁹ Neither the fact that her condition manifested itself during a period of employment, nor her belief that the condition was caused, precipitated or aggravated by her employment is sufficient to establish causal relationship.¹⁰

While appellant claims to have sustained employment-related injuries to both her neck and shoulders, the Board notes that there is no specific diagnosis relative to her shoulders or upper extremities. There is evidence of radicular symptoms in the upper extremities, but no specific diagnosis with respect to appellant's shoulders or upper extremities. The medical evidence indicates that her shoulder and upper extremity complaints stem from her cervical condition.

⁷ 20 C.F.R. § 10.115(e), (f) (2011); see *Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996). Causal relationship is a medical question, which generally requires rationalized medical opinion evidence to resolve the issue. See *Robert G. Morris*, 48 ECAB 238 (1996). A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factors must be based on a complete factual and medical background. *Victor J. Woodhams*, 41 ECAB 345, 352 (1989). Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factors. *Id.*

⁸ *Victor J. Woodhams*, *supra* note 7.

⁹ *Jaja K. Asaramo*, 55 ECAB 200, 204 (2004).

¹⁰ *D.I.*, 59 ECAB 158, 162 (2007).

Appellant believes that the same employment exposure that was responsible for her lumbar condition also caused her cervical condition. While the record is replete with references to ongoing lumbar and lower extremity complaints, there are considerably fewer references to her neck, shoulder and upper extremity complaints. Although appellant believes her cervical condition is employment related, no physician of record has specifically attributed her cervical condition to her previous nursing duties. Dr. Washington, Dr. Soren and Dr. Schwab merely reiterated appellant's belief that her cervical condition was related to her employment injuries while working as nurse. No physician offered a rationalized medical opinion addressing the a causal relationship between appellant's nursing duties and her cervical disc disease.

The record demonstrates that appellant had cervical disc disease dating back as early as August 2005. Appellant, however, has failed to establish that her nursing duties either caused or contributed to her diagnosed cervical condition. Accordingly, OWCP properly declined to expand her claim to include her cervical and shoulder complaints.

CONCLUSION

Appellant has not established that her claimed neck and shoulder conditions are employment related.

ORDER

IT IS HEREBY ORDERED THAT the April 28, 2011 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 2, 2012
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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