United States Department of Labor
Employees' Compensation Appeals Board

K.P., Appellant	)	
and	)	**Docket No. 14-1330**
	)	**Issued: October 17, 2014**
U.S. POSTAL SERVICE, POST OFFICE, Columbus, OH, Employer	)	

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
COLLEEN DUFFY KIKO, Judge
PATRICIA HOWARD FITZGERALD, Judge

JURISDICTION

On May 22, 2014 appellant, through counsel, filed a timely appeal from a March 12, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP) hearing representative. Pursuant to the Federal Employees' Compensation Act[1] (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 her burden of proof to establish left upper extremity and cervical conditions causally related to a November 17, 2011 employment incident.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that appellant submitted additional evidence following the March 12, 2014 decision. Since the Board's jurisdiction is limited to evidence that was before OWCP at the time it issued its final decision, the Board may not consider this evidence for the first time on appeal. *See* 20 C.F.R. § 501.2(c); *Sandra D. Pruitt*, 57 ECAB 126 (2005). Appellant may submit that evidence to OWCP along with a request for reconsideration.

FACTUAL HISTORY

On December 17, 2012 appellant, then a 57-year-old postmaster, filed a traumatic injury claim alleging that on November 17, 2011 she sustained injuries to her left elbow, left hand and neck when her toe caught on a flat tub and caused her to fall on her left side. The employing establishment reported that her notice was received on January 30, 2013.

In a November 17, 2011 hospital record, Dr. Matthew B. Smith, a Board-certified family practitioner, examined appellant for complaints of bilateral wrist discomfort after she fell down at work. He reviewed her history and noted a history of osteopenia. Upon examination of appellant's wrist, Dr. Smith observed moderate tenderness and full range of motion with no neurovascular deficits. He diagnosed right wrist sprain. Dr. Smith included an x-ray report of the left wrist which revealed a normal examination.

In an October 3, 2012 report, Dr. Desmond J. Stutzman, a Board-certified orthopedic surgeon, related appellant's complaints of pain, swelling, weakness and numbness in her left upper extremity after she fell down on a concrete floor at work on November 17, 2011. Appellant stated that she fell on her left side to protect her right side where she recently had surgery. Dr. Stutzman reviewed her history and reported no significant findings. He noted that appellant had multiple examinations and treatment for her right upper extremity. Upon examination, Dr. Stutzman observed positive Tinel's sign at the level of the left wrist for the median nerve and negative at the elbow for the ulnar nerve. He reported no swelling, ecchymosis or erythema and intact radial and ulnar arteries. Dr. Stutzman stated that x-rays of appellant's left thumb and wrist revealed no evidence of any bony abnormality, pattern of instability or fracture. He also related that a March 22, 2012 electromyography (EMG) and nerve conduction velocity (NCV) examination demonstrated mild ulnar nerve slowing across the left elbow and mild nerve slowing across the wrist. Dr. Stutzman diagnosed mild carpal tunnel syndrome and mild ulnar nerve neuritis of the left upper extremity. He opined that it was possible that appellant's current symptoms were related to her fall at work. Dr. Stutzman explained that the only connection was that she claimed that she did not have any symptoms prior to the fall. He included the EMG/NCV examination report by Dr. Martin Taylor, a Board-certified neurologist.

In a letter dated February 14, 2013, Michael B. Alter, a health and resource specialist at the employing establishment, controverted appellant's claim on the grounds that she did not file a claim until one-year past the date of the alleged injury, which prevented management from performing an investigation on the day of the alleged injury. He also contended that she did not provide any medical documentation to support her claim.

By letter dated February 15, 2013, OWCP advised appellant that the evidence submitted was insufficient to establish her claim and requested additional evidence to establish that she sustained a traumatic injury in the performance of duty.

In a March 14, 2013 narrative letter, Dr. Michael J. Simek, Board-certified in physical medicine and rehabilitation, examined appellant for complaints of right-sided neck and shoulder pain. He noted that she had a history of right shoulder pain with a partial rotator cuff tear and chronic intermittent neck pain with underlying cervical degenerative disc disease. Upon

examination, Dr. Simek observed mild tenderness to palpation over appellant's right cervical paraspinals and trapezius. He also noted normal sensation to light touch in all dermatomes throughout. Manual muscle testing revealed 5/5 strength in all major muscle groups in the bilateral upper limits. Dr. Simek reported pain on range of motion throughout appellant's right shoulder, especially with internal and external rotation. Spurling's maneuver was negative bilaterally. Dr. Simek diagnosed right-sided neck pain with overlying myofascial symptomatology and underlying preexisting disc disease at the C5-6 and C6-7 levels with disc protrusion and right shoulder pain with partial rotator cuff tear. He opined that from a cervical spine standpoint, appellant's pain seemed to be myofascial in etiology, which could be related to her splinting and shoulder pain as opposed to her underlying cervical issues.

In a decision dated March 29, 2013, OWCP denied appellant's traumatic injury claim. It accepted that the November 17, 2011 incident occurred as alleged and that she sustained a diagnosed medical condition but denied her claim due to insufficient medical evidence to establish that her degenerative cervical condition was causally related to the accepted incident.

By letter dated April 15, 2013 and received on April 16, 2013, counsel requested a telephone hearing, which was held on August 14, 2013. Appellant described the November 17, 2011 incident at work. She went back to pick up a big bulk of mail on a flat tub when her toe got caught and caused her to fall and hurt her left elbow, hand and neck. Appellant explained that she previously had surgery on her right hand in May so she fell down mainly on her left side to protect her right side. She reported the injury to her supervisor that evening. Appellant related that after work she went to Urgent Care and was told that she had sprained both wrists. When she continued to experience pain in her left hand and began to experience a little pain in her neck, she had a follow-up examination with Dr. Cush in January. Appellant underwent an EMG which demonstrated abnormal findings. She explained that she did not file a traumatic injury claim until December 2012 because that was when she began to have issues with her wrist, elbow, hand and fingers.

In a May 29, 2013 attending physician's report, Dr. Stutzman stated that appellant underwent a right carpal tunnel revision in 2011 due to continual repetitive work with arms and hands. He noted that findings of a magnetic resonance imaging (MRI) scan of the right hand and diagnosis codes. Dr. Stutzman checked a box marked "yes" that appellant's condition was caused or aggravated by constant, repetitive work with arm and hands. He indicated that she was disabled from June 18 to July 18, 2013.

In a June 1, 2013 narrative report, Dr. C. Christopher Fiumera, a psychologist, stated that he met with appellant four times and diagnosed mood disorder due to a general medical condition and panic disorder without agoraphobia. He related that she continued to deal with numerous medical issues since May 2007 and noted that medical records indicated that she was seen by multiple providers who had treated her with a variety of surgical procedures, rehabilitation and pain medication. Dr. Fiumera stated that appellant was unable to physically perform her work duties.

In an August 16, 2013 report, Dr. Stutzman stated that appellant was seen on October 3, 2012 for resulting injuries from a November 17, 2011 fall onto a concrete floor at work. He noted that at that time she complained of pain, swelling, weakness and numbness in

the left upper extremity. Dr. Stutzman reported that examination during the visit demonstrated positive Tinel's sign at the level of the wrist for the median nerve and negative Tinel's sign at the elbow for the ulnar nerve. He related that there was a nondescript pain at appellant's wrist but no evidence of instability or bony abnormality. Dr. Stutzman reported that an EMG/NCV on the left side revealed carpal tunnel and cubital tunnel syndrome. He diagnosed carpal tunnel syndrome and ulnar nerve neuritis of the left upper extremity. Dr. Stutzman explained that regarding causal relationship, he could only base the direct relationship on the fact that appellant did not have symptoms of carpal tunnel syndrome and cubital tunnel syndrome prior to her fall. He stated that it was well documented that carpal tunnel syndrome and cubital tunnel syndrome could be caused by direct trauma and that would be what he would base as the causal relationship.

In a November 6, 2013 report, Dr. Stutzman reexamined appellant for her left upper extremity. He related that her complaints of aching and intermittent numbness if she used her left upper extremity or if the elbow was placed in the wrong position. Upon examination, Dr. Stutzman observed full range of motion of the elbow and hand. He reported positive Tinel's test at the level of the wrist for the median nerve and at the elbow for the ulnar nerve. Carpal compression and Phalen's sign maneuver were also positive. Dr. Stutzman reported no swelling, ecchymosia or erythema. Neurological examination was intact to the upper extremity. Dr. Stutzman diagnosed left carpal tunnel syndrome and left ulnar nerve neuropathy at the elbow. He recommended a more recent EMG/NCV examination for the left upper extremity and surgical intervention.

By decision dated March 12, 2014, an OWCP hearing representative affirmed the March 29, 2013 decision denying appellant's traumatic injury claim. He noted that she had an accepted prior claim for right carpal tunnel syndrome, but that the medical evidence was insufficient to establish that she sustained a left upper extremity and cervical conditions causally related to the November 17, 2011 employment incident.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] has the burden of proof to establish the essential elements of his or her claim by the weight of the reliable, probative and substantial evidence[4] including that he or she sustained an injury in the performance of duty and that any specific condition or disability for work for which he or she claims compensation is causally related to that employment injury.[5]

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.[6] There are two components involved in establishing the fact of injury. First, the employee must

[3] 5 U.S.C. §§ 8101-8193.

[4] *J.P.*, 59 ECAB 178 (2007); *Joseph M. Whelan*, 20 ECAB 55, 58 (1968).

[5] *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[6] *S.P.*, 59 ECAB 184 (2007); *Alvin V. Gadd*, 57 ECAB 172 (2005).

submit sufficient evidence to establish that she actually experienced the employment incident at the time, place and in the manner alleged.[7] Second, the employee must submit evidence, generally only in the form of probative medical evidence, to establish that the employment incident caused a personal injury.[8] An employee may establish that the employment incident occurred as alleged but fail to show that her disability or condition relates to the employment incident.[9]

Whether an employee sustained an injury in the performance of duty requires the submission of rationalized medical opinion evidence.[10] The opinion of the physician must be based on a complete factual and medical background of the employee, 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 employee.[11] The weight of the 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.[12]

ANALYSIS

Appellant alleges that she sustained left upper extremity and cervical conditions as a result of a November 17, 2011 employment incident. The record substantiates that she had a prior right wrist injury, which was accepted for carpal tunnel syndrome and surgical repair. Appellant has not alleged that she sustained injury to her right upper extremity on November 17, 2011. OWCP accepted that the November 17, 2011 employment incident occurred as alleged and that she was diagnosed with cervical and left upper extremity conditions but it denied her claim finding insufficient medical evidence to establish that her diagnosed conditions were causally related to the accepted November 17, 2011 employment incident.

Appellant was initially examined at the hospital on November 17, 2011 by Dr. Smith, who related that she fell down at work and experienced pain in both her wrists. Dr. Smith conducted an examination and diagnosed right wrist sprain. Regarding appellant's left wrist, he noted that x-rays were within normal limits. The Board notes that, although Dr. Smith mentions that appellant fell down at work and provided a diagnosis, he does not clarify whether her fall at work caused or contributed to her diagnosed condition. The Board has found 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.[13]

[7] *Bonnie A. Contreras*, 57 ECAB 364 (2006); *Edward C. Lawrence*, 19 ECAB 442 (1968).

[8] *David Apgar*, 57 ECAB 137 (2005); *John J. Carlone*, 41 ECAB 354 (1989).

[9] *T.H.*, 59 ECAB 388 (2008); *see also Roma A. Mortenson-Kindschi*, 57 ECAB 418 (2006).

[10] *See J.Z.*, 58 ECAB 529 (2007); *Paul E. Thams*, 56 ECAB 503 (2005).

[11] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 465 (2005).

[12] *James Mack*, 43 ECAB 321 (1991).

[13] *R.E.*, Docket No. 10-679 (issued November 16, 2010); *K.W.*, 59 ECAB 271 (2007).

Appellant was also examined by Dr. Stutzman on several occasions. In reports dated October 3, 2012 to November 6, 2013, Dr. Stutzman noted her complaints of pain and numbness in her left upper extremity were due to her fall on a concrete floor at work on November 17, 2011. Upon examination, he observed positive Tinel's sign at the level of the left wrist for the median nerve and negative at the elbow for the ulnar nerve. Dr. Stutzman stated that x-rays did not reveal any evidence of any bony abnormality, pattern of instability or fracture. He also noted that a March 22, 2012 EMG/NCV examination demonstrated mild ulnar nerve slowing across the left elbow and mild nerve slowing across the wrist. Dr. Stutzman diagnosed mild carpal tunnel syndrome and mild ulnar nerve neuritis of the left upper extremity. In October 3, 2012 and August 6, 2013 reports, he stated that it was possible that appellant's current symptoms were related to her fall at work. Dr. Stutzman explained that he could only base the direct relationship on the fact that she did not have symptoms of carpal tunnel syndrome and cubital tunnel syndrome prior to her fall. He stated that carpal tunnel syndrome and cubital tunnel syndrome could be caused by direct trauma.

The Board notes that Dr. Stutzman provided an accurate history of the November 17, 2011 incident and findings on examination. Dr. Stutzman diagnosed mild carpal tunnel syndrome and mild ulnar nerve neuritis. Regarding causal relationship, he opined that it was possible that appellant's current symptoms were related to her fall at work. He explained that the only basis for his opinion was that she did not have symptoms of carpal tunnel syndrome or cubital tunnel syndrome prior to the November 17, 2011 fall at work. The Board has held, however, that an opinion that a condition is causally related because the employee was asymptomatic before the injury is insufficient, without sufficient rationale, to establish causal relationship.[14] In this case, Dr. Stutzman has provided no medical rationale or explanation sufficient to establish that the November 17, 2011 work incident caused or contributed to appellant's diagnosed conditions. Furthermore, his opinion that it was "possible" that her left upper extremity conditions were related to her fall at work is speculative or equivocal in character and is of diminished probative value.[15] The Board also notes that Dr. Stutzman did not examine appellant until almost a year after the alleged November 17, 2011 employment injury and he does not explain how her present symptoms are causally related to an incident that occurred one year earlier. For these reasons, the Board finds that his reports are insufficient to establish appellant's claim.

Appellant also submitted a March 14, 2013 report by Dr. Simek who noted that he examined appellant for complaints of myofascial pain in her neck. Dr. Simek noted her history of right shoulder pain with a partial rotator cuff tear and chronic intermittent neck pain with underlying cervical degenerative disc disease. Upon examination, he observed mild tenderness to palpation over appellant's right cervical paraspinals and trapezius. Dr. Simek reported pain on range of motion throughout her right shoulder, especially with internal and external rotation. Spurling's maneuver was negative bilaterally. Dr. Simek diagnosed right-sided neck pain with overlying myofascial symptomatology and underlying degenerative disc disease at the C5-6 and C6-7 levels with disc protrusion and right shoulder pain with partial rotator cuff tear. He stated that from a cervical spine standpoint, appellant's pain seemed to be myofascial in etiology,

[14] *T.M.*, Docket No. 08-975 (issued February 6, 2009); *Michael S. Mina*, 57 ECAB 379 (2006).

[15] *D.D.*, 57 ECAB 734, 738 (2006); *Kathy A. Kelley*, 55 ECAB 206 (2004).

which could be related to her splinting and shoulder pain as opposed to her underlying cervical issues.

While Dr. Simek provides a medical diagnosis based on physical examination, the Board notes that he does not mention the November 17, 2011 employment incident nor explain, based on medical rationale, how appellant's cervical conditions and right shoulder symptoms were causally related to her fall on the left side at work. The Board has found that a physician must provide a narrative description of the identified employment incident and a reasoned opinion on whether the employment incident described caused or contributed to appellant's diagnosed medical condition.[16] A well-rationalized opinion is particularly warranted in this case due to appellant's history of preexisting conditions. As Dr. Simek has not provided a reasoned opinion on whether her current cervical condition is related to the November 17, 2011 incident or her underlying preexisting condition, the Board finds that his report is of diminished probative value.

Similarly, Dr. Fiumera's June 1, 2013 psychology report is also insufficient to establish appellant's claim as he fails to mention the November 17, 2011 incident nor relate any of her cervical or left upper extremity conditions to the accepted employment incident.

Causal relationship is a medical issue that can only be shown by reasoned medical opinion evidence that is supported by medical rationale.[17] As appellant has not provided such reasoned medical opinion to establish a causal relationship between her cervical and left upper extremity conditions and the November 17, 2011 employment incident, the Board finds that OWCP properly denied her traumatic injury claim.

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 her burden of proof to establish that her left upper extremity and cervical conditions were causally related to the November 17, 2011 employment incident.

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

[17] *T.H.*, 59 ECAB 388 (2008); *see also Roma A. Mortenson-Kindschi*, 57 ECAB 418 (2006).

ORDER

IT IS HEREBY ORDERED THAT the March 12, 2014 merit decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 17, 2014
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Patricia Howard Fitzgerald, Judge
Employees' Compensation Appeals Board