United States Department of Labor
Employees' Compensation Appeals Board

A.D., Appellant	)	
and	)	**Docket No. 16-0764**
	)	**Issued: August 25, 2016**
DEPARTMENT OF THE INTERIOR, WESTERN REGIONAL OFFICE, Phoenix, AZ, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 7, 2016 appellant filed a timely appeal of an October 8, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). 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.

ISSUE

The issue is whether appellant has met her burden of proof to establish an injury causally related to a May 20, 2014 employment incident.

FACTUAL HISTORY

On May 20, 2014 appellant, then a 52-year-old school bus driver, filed a Form CA-1, notice of traumatic injury, alleging that on that same date she tripped on a sidewalk west of the

[1] 5 U.S.C. § 8101 *et seq.*

gymnasium of San Simon School and fell scraping her knee and jostling her neck, back, hip, and right hand. The employing establishment indicated that she was in the performance of duty. Appellant did not stop work.

Appellant was treated by Dr. Allen B. Lee, an osteopath, on July 16, 2014. Dr. Lee noted findings on examination of dizziness, headache, nausea, and back and joint pain. He diagnosed chronic low back pain. Appellant was treated by a physician assistant on July 31, 2014 for left hip pain and lower back pain. She reported that, on May 20, 2014, she fell on an uneven side walk in front of a gymnasium and she continued to have left hip pain and low back pain. The physician assistant noted that appellant's history was significant for a bone graph from the left hip to repair the right scaphoid, left knee partial patellectomy, neck stenosis, and three screws in her left hip.

On September 18, 2014 OWCP advised appellant that her claim was originally received as a simple, uncontroverted case with minimal or no time loss from work. The claim was administratively handled to allow medical payments up to $1,500.00. OWCP advised that, because the medical bills exceeded $1,500.00, appellant's claim would be formally adjudicated. It requested that she submit additional evidence including a comprehensive medical report explaining how the specific work incidents contributed to her claimed condition.

Appellant submitted an undated statement describing the May 20, 2014 incident. She noted seeking treatment from a chiropractor. Appellant reported sustaining injuries to her lumbar and hip in a prior motor vehicle accident, which was aggravated by this fall. She reported being on the employing establishment's premises when she fell. Appellant submitted witness statements from persons who either saw her fall or saw her immediately after the fall.

Appellant submitted several medical reports regarding her past and current treatment. On April 4, 2013 she was treated by Dr. Richard Reams, a Board-certified family practitioner, for musculoskeletal pain. Appellant reported falling at work and injuring her left hip and right upper arm when she went to sit on a chair in the gym and a student moved the chair from beneath her. Dr. Reams noted an antalgic gait, tenderness of the left lower back and buttock area, left lateral hip pain, and neck pain. He diagnosed back sprain, neck sprain, and fall.[2]

In a July 31, 2014 report, Dr. Lee treated appellant for left hip and lower back pain. Appellant reported that on May 20, 2014 she fell on an uneven sidewalk in front of a gymnasium. Dr. Lee noted thoracic spine spasm, mild pain with motion, tenderness of the lumbar spine, and crepitus of the left hip. He diagnosed thoracic back pain, moderate multilevel degenerative changes within the thoracic spine, left hip pain, three compression screws within the proximal left femur, slight irregularity of the left femoral head, which could be due to

[2] Appellant provided a February 20, 1998 report from Dr. Stephen R. Stein, a Board-certified orthopedic surgeon, who saw her for left hip and left knee injuries incurred in an August 8, 1995 motorcycle accident. She had an open reduction internal fixation of the left hip, pinning of a femoral neck fracture, and resection of the majority of her patella for a comminuted fracture. Appellant had a prior history of a right wrist scaphoid fracture and a left ankle fracture. An April 4, 2013 pelvic x-ray showed stable postoperative changes and old trauma. An October 4, 2013 left hip x-ray revealed left femur compression screws, stable postoperative changes, mild left hip degenerative changes, and flattening of the left femoral head possibly due to avascular necrosis.

underlying vascular necrosis, pain in low back, mild loss of height of L1 vertebral body, and mild bilateral facet hypertrophy at L3-4, L4-5, and L5-S1.

Appellant was seen by Dr. Nicholas A. Ransom, a Board-certified orthopedist, on September 22, 2014, for cervical and lumbar spine pain from a long-standing condition that was exacerbated on May 20, 2014. Dr. Ransom noted that the mechanism of injury was a fall and reinjury of previous condition to the low back from an original motor vehicle injury. He noted that appellant had a prior history of cervical and lumbar pain made worse by the May 20, 2014 work injury. Appellant's history was significant for left hip surgery, left patellectomy and right scaphoid surgery. Dr. Ransom noted tenderness at the lumbosacral and cervical junction, limited range of motion of the lumbar spine with intact motor, sensory, and reflexes. He diagnosed cervicalgia and lumbar backache. Dr. Ransom noted the etiology of appellant's pain was multiple level spondylosis. Appellant also provided records from a physician assistant.

By decision dated November 3, 2014, OWCP denied appellant's compensation claim, finding that the medical evidence of record was not sufficient to establish that a medical condition was diagnosed in connection with the claimed event or work factors.

On November 24, 2014 appellant requested an oral hearing which was held before an OWCP hearing representative on July 7, 2015. She submitted a November 26, 2014 report from Dr. Ransom who treated her for constant cervical spine pain, occipital headaches, and left C5 radiculopathy. Dr. Ransom diagnosed cervical central canal stenosis by magnetic resonance imaging (MRI) scan and recommended a discectomy. On December 16, 2014 he treated appellant for worsening cervical pain since the May 2014 work event when she reported tripping and falling on a sidewalk and twisting her neck. Appellant developed neck pain, occipital headaches, and left arm pain in the left C5 radicular distribution. Dr. Ransom advised that she had a history of cervical problems and was involved in a rollover motor vehicle accident in 2006. From 2007 to 2014, appellant had very few symptoms, but since the 2014 traumatic event she was unable to participate in activities of daily living. Dr. Ransom noted a November 14, 2014 MRI scan revealed spinal stenosis at C6-7 with myelomalacia of the cord. He opined that given appellant's symptoms and cervical stenosis decompression surgical stabilization of the C6-7 level was recommended.

Dr. Sergio Rivero, a Board-certified neurosurgeon, saw appellant on January 26, 2015, for cervical stenosis. Appellant reported falling in May 2014 and having numbness and tingling in her hands as well as weakness in her arms, and legs. Her history was significant for a motorcycle accident. Dr. Rivero diagnosed cervical stenosis of spinal canal, myelomalacia of the cervical cord and myelopathy, and recommended a cervical discectomy. In a March 12, 2015 operative report, he performed a C5-6 and C6-7 anterior cervical discectomy, decompression of the spinal cord and osteophytectomy at C5-7, anterior interbody arthrodesis at C5-6, C6-7, and C5-7 anterior plate and screws. Dr. Rivero diagnosed cervical stenosis with myelomalacia. On March 27, 2015 he diagnosed status post cervical spinal fusion. Dr. Rivero noted that appellant was doing well postoperatively. In a May 1, 2015 report he treated appellant for pain in the occipital area. Dr. Rivero noted the March 12, 2015 surgery and diagnosed status post cervical spinal fusion. He noted cervical spine x-rays revealed status post anterior cervical discectomy with fusion from C5-7 with the hardware intact. Dr. Rivero referred appellant for physical therapy

In a July 29, 2015 report, Dr. David Parke, a chiropractor, treated appellant for chronic musculoskeletal pain, which he traced back to a motorcycle accident on August 22, 1995. He noted that she tripped on an uneven section of sidewalk on May 20, 2014. Dr. Parke treated appellant for pain in the neck, upper trapezius, shoulders, low back, and left knee. He noted a worsening of her condition which began immediately after the fall on May 20, 2014. Dr. Parke opined that the fall definitely contributed to the degeneration and destabilization of her neck which led to surgery on March 12, 2015. He further noted that it was likely, although not certain, that the fall on May 20, 2014 destabilized an already compromised cervical spine and caused the need for surgery.

Appellant submitted an August 26, 2015 report from Dr. Moeen Din, a Board-certified neurologist, who treated her for cervical spinal stenosis and severe cord compression at C6-7 with myelomalacia causing weakness in the upper and lower extremities. Dr. Din noted that there was a "possibility" that a fall could have aggravated her spinal stenosis.[3]

By decision dated October 8, 2015, an OWCP hearing representative affirmed the November 3, 2014 decision.

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 of FECA, that an injury was sustained in the performance of duty as alleged and that any disability and/or specific condition for which compensation is claimed is causally related to the employment injury. 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.[4]

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. There are two components involved in establishing fact of injury. First, the employee must submit sufficient evidence to establish that he actually experienced the employment incident at the time, place, and in the manner alleged. Second, the employee must submit medical evidence to establish that the employment incident caused a personal injury.[5]

[3] Appellant also submitted diagnostic test reports. An August 21, 2014 cervical spine x-ray revealed osteophyte spurring at C5-6 and C6-7, loss of normal cervical curve, and uncovertebral joint arthrosis at C3-4, C4-5, C5-6, C6-7, and C7-T1. A November 14, 2014 cervical spine MRI scan showed posterior ridging with cord compression consistent with spinal stenosis and myelomalacia at C6-7, right foraminal stenosis at C3-4 and C4-5, bilateral foraminal stenosis at C6-7 and C7-T1, and a disc bulge at C5-6. A July 6, 2015 electromyogram showed right peroneal neuropathy. An August 13, 2015 cervical spine MRI scan revealed posterior ridging and cord compression at C6-7 consistent with spinal canal stenosis, myelomalacia of the cord, and bilateral foraminal stenosis at C6-7. An August 13, 2015 MRI scan of the thoracic spine showed no evidence of disc herniation and an eight-millimeter hemangioma body at T7.

[4] *Gary J. Watling*, 52 ECAB 357 (2001).

[5] *T.H.*, 59 ECAB 388 (2008).

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.[6]

ANALYSIS

It is not disputed that on May 20, 2014 appellant, a school bus driver, tripped on a sidewalk at a school and fell to the ground. However, the Board finds that she has not submitted sufficient medical evidence to establish that any of her diagnosed conditions are causally related to this accepted employment incident.

Dr. Ransom, in a September 22, 2014 report, noted treating appellant for a long-standing cervical and lumbar spine condition. He noted that the mechanism of injury was a fall and reinjury of a previous low back condition from an original motor vehicle injury. Dr. Ransom diagnosed cervicalgia and lumbar backache and advised that appellant's cervical and lumbar pain was exacerbated by the May 20, 2014 work injury. In reports dated November 26 and December 16, 2014, he noted her worsening cervical pain since the May 2014 fall at work after which she developed neck pain, occipital headaches, and left arm pain in the left C5 radicular distribution. Dr. Ransom advised that appellant had a history of cervical problems, but that, from 2007 to 2014, she had very few symptoms. However, since the 2014 traumatic event, appellant was unable to participate in activities of daily living. Although Dr. Ransom supported causal relationship, he did not provide medical rationale explaining the basis of his conclusory opinion regarding the causal relationship between her diagnosed cervicalgia, multiple level spondylosis, spinal stenosis at the C6-7 with myelomalacia of the cord, and the May 20, 2014 fall at work.[7] He did not explain the process by which tripping on a sidewalk and falling would cause or aggravate appellant's diagnosed conditions and why such conditions would not be only due to any of her previous nonwork injuries or to multilevel age-related degenerative disc disease. The need for medical reasoning is particularly important as the record indicates that appellant has preexisting conditions affecting the same areas of her body. Thus, Dr. Ransom's reports are insufficient to meet her burden of proof.

Appellant submitted treatment notes from Dr. Reams. Dr. Reams noted that appellant reported falling at work and injuring her left hip and right arm when she went to sit in a chair in the gym and a student moved the chair from beneath her. However, he provided no rationale relating the fall to his diagnosis of back sprain, neck sprain and fall. Therefore, his reports are insufficient to meet appellant's burden of proof.

Appellant was treated by Dr. Lee on July 16 and 31, 2014 for left hip and lower back pain. She reported that on May 20, 2014 she fell on uneven side walk at work. Dr. Lee

[6] *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[7] *See T.M.*, Docket No. 08-975 (issued February 6, 2009) (a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale).

diagnosed thoracic back pain, moderate multilevel degenerative changes within the thoracic spine, left hip pain, three compression screws within the proximal left femur, slight irregularity of the left femoral head which could be due to underlying vascular necrosis, pain in low back, mild loss of height of L1 vertebral body, and mild bilateral facet hypertrophy at L3-4, L4-5, and L5-S1. However, he appears merely to be repeating the history of injury as reported by appellant without providing his own opinion regarding whether her condition was work related.[8] To the extent that Dr. Lee is providing his own opinion, he failed to provide a rationalized opinion regarding the causal relationship between her condition and the factors of employment believed to have caused or contributed to such condition.[9]

In an August 26, 2015 report, Dr. Din noted initially evaluating appellant on January 15, 2015 after she had a fall at work and she reported worsening symptoms involving cervical spinal stenosis in the cervical region as well as severe cord compression at C6-7 with myelomalacia. He noted that there was a "possibility" that a fall could have aggravated her spinal stenosis. Dr. Din's report provides some support for causal relationship, but is insufficient to establish the claimed conditions are causally related to the fall at work. At best, this report provides only speculative support for causal relationship as he qualifies his support by noting that there was a "possibility" that appellant's fall on May 20, 2014 caused her condition. Dr. Din provided no medical reasoning to support his opinion on causal relationship. Therefore, this report is insufficient to meet appellant's burden of proof.[10]

Appellant was treated by Dr. Rivero on January 26, 2015 for cervical stenosis. She reported falling in May 2014 and experienced numbness and tingling in her hands and weakness in her arms and legs. Dr. Rivero diagnosed cervical stenosis of spinal canal, myelomalacia of the cervical cord, and myelopathy. In subsequent reports, he noted performing surgery and appellant's postsurgical progress. These reports are insufficient to establish the claim as Dr. Rivero did not specifically relate her conditions, by cause or aggravation, to the May 2014 incident at work nor did he otherwise explain the process by which the employment incident would have caused or aggravated particular diagnosed conditions.[11]

Appellant submitted a July 29, 2015 report from Dr. Parke, a chiropractor, who treated her for chronic musculoskeletal pain since a motorcycle accident on August 22, 1995. He noted that she had another fall at work on May 20, 2014 when she tripped on an uneven section of sidewalk. Dr. Parke opined that the fall definitely contributed to the degeneration and destabilization of appellant's neck, which led to surgery on March 12, 2015. However, section 8101(2) of FECA provides that chiropractors are considered physicians "only to the extent that

[8] *Frank Luis Rembisz*, 52 ECAB 147 (2000) (medical opinions based on an incomplete history or which are speculative or equivocal in character have little probative value).

[9] *Franklin D. Haislah*, 52 ECAB 457 (2001) (medical reports not containing rationale on causal relationship are entitled to little probative value); *Jimmie H. Duckett*, 52 ECAB 332 (2001).

[10] Medical opinions that are speculative or equivocal in character are of diminished probative value. *D.D.*, 57 ECAB 734 (2006).

[11] *A.D.*, 58 ECAB 149 (2006) (medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist and subject to regulation[s] by the Secretary."[12] Thus, where x-rays do not demonstrate a subluxation (a diagnosis of a subluxation based on x-rays has not been made), a chiropractor is not considered a "physician," and his or her reports cannot be considered as competent medical evidence under FECA.[13] The Board finds that Dr. Parke is not considered a physician under FECA as he did not diagnose a spinal subluxation demonstrated by x-ray. Thus, his opinion is of no probative medical value. Likewise, appellant was also treated by a physician assistant. However, the Board has held that documents or notes signed by a physician assistant are not considered medical evidence as a physician assistant is not a physician under FECA.[14] Thus, the treatment records from the physician assistant have no probative medical value in establishing appellant's claim for cervical pain.

The remainder of the medical evidence is of limited probative value as it either predates the claimed injury or fails to provide an opinion on the causal relationship between appellant's job and her diagnosed cervical condition.[15] For this reason, this evidence is not sufficient to meet her burden of proof.

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 an injury causally related to a May 20, 2014 employment incident.

[12] 5 U.S.C. § 8101(2); *see also* section 10.311 of the implementing federal regulations provides: "(c) A chiropractor may interpret his or her x-rays to the same extent as any other physician. To be given any weight, the medical report must state that x-rays support the finding of spinal subluxation. OWCP will not necessarily require submittal of the x-ray, or a report of the x- ray, but the report must be available for submittal on request."

[13] *See Susan M. Herman,* 35 ECAB 669 (1984).

[14] *See David P. Sawchuk*, 57 ECAB 316 (2006) (lay individuals such as physician assistants, nurses and physical therapists are not competent to render a medical opinion under FECA); 5 U.S.C. § 8101(2) (this subsection defines a "physician" as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law).

[15] *See supra* note 11.

ORDER

IT IS HEREBY ORDERED THAT the October 8, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 25, 2016
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board