United States Department of Labor
Employees' Compensation Appeals Board

C.J., Appellant	)	
and	)	**Docket No. 15-1697**
	)	**Issued: February 5, 2016**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Atlanta, GA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 6, 2015 appellant, through counsel, timely appealed a June 24, 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.[2]

ISSUE

The issue is whether appellant's closed fracture of the left distal radius is causally related to the September 30, 2014 employment incident.

[1] 5 U.S.C. §§ 8101 *et seq.*

[2] The case record provided to the Board includes evidence received after OWCP issued its June 24, 2015 decision. The Board is precluded from considering evidence that was not in the case record at the time OWCP rendered its final decision. 20 C.F.R. § 501.2(c)(1).

FACTUAL HISTORY

On September 30, 2014 appellant, then a 59-year-old modified rural carrier, was walking around the employee parking lot during her lunch break when she tripped, stumbled, and fell. At the time, she was accompanied by a coworker, Varonda Williams. Appellant fell forward and hit the ground with her left hand extended outward. Ms. Williams indicated that she was walking ahead of appellant and when she looked back, she saw appellant had fallen. She helped appellant up and noted that appellant was holding her left hand. Additionally, Ms. Williams reported that, by the time they returned to the building, appellant's hand had begun to swell.

Appellant initially sought treatment at Concentra Medical Centers' (CMC) urgent care facility, but later transferred to Atlanta Medical Center's (AMC) emergency department. The employing establishment completed a Form CA-16 authorizing appellant's initial September 30, 2014 medical examination and treatment. Appellant's supervisor, Mary Daniel, accompanied her to CMC.

According to the September 30, 2014 CMC treatment records, appellant reported that she had tripped and fell while walking through the company parking lot, landing on her left side, and injuring her left wrist and hand. She immediately felt sharp (10/10) left wrist pain. The CMC treatment records identified appellant as a postal worker, and also noted a prior surgical history of right and left rotator cuff repairs in 2012 and 2013, respectively. X-rays of her left wrist and forearm revealed a fracture of the distal radius. Appellant received a diagnosis of closed fracture of the left distal radius (ICD-9 813.42), and she was referred to AMC's emergency department for further evaluation.[3] Additional left hand/wrist/forearm x-rays obtained at AMC revealed a comminuted impacted distal radius fracture and mild widening of the scapholunate (SL) space.[4]

Appellant returned to CMC for follow up on October 2, 2014 where she was treated by Annette S. Williams, PA-C. At the time, her left arm was noted to be "casted from hand to distal humerus." CMC personnel referred appellant to an orthopedic specialist for further evaluation.

Dr. Gary M. Lourie, a Board-certified orthopedic surgeon with a subspecialty in hand surgery, examined appellant on October 14, 2014. He noted that she had sustained a hyper-dorsiflexion injury to her left wrist on September 30, 2014. Dr. Lourie diagnosed distal radius intra-articular dorsal comminution and possible SL dissociation. He recommended open reduction and internal fixation (ORIF) of the left distal radius and possible repair of the SL ligament, which was scheduled for October 22, 2014.

OWCP also received Dr. Lourie's follow-up treatment notes for October 17 and 23, and November 4, 2014, as well as a brief note regarding appellant's October 22, 2014 surgery. With

[3] While at CMC, Jennifer J. Jackson, a certified physician assistant (PA-C), examined and treated appellant. The September 30, 2014 CMC treatment records note that the "case was reviewed and discussed with Dr. [Kathleen M.] Gunchick," who agreed with the management plan. Dr. Gunchick is Board-certified in emergency medicine, but neither Ms. Jackson nor Dr. Gunchick signed the September 30, 2014 CMC treatment records.

[4] An October 1, 2014 left wrist computerized tomography (CT) scan also revealed a distal radius fracture and widening of the interval between the scaphoid and lunate, consistent with a ligamentous injury. Dr. Alan R. Johnson, a Board-certified diagnostic radiologist, interpreted appellant's left wrist CT scan.

respect to the latter, Dr. Lourie identified appellant's left wrist pre- and postoperative diagnosis, and described the October 22, 2014 surgical procedure as "ORIF three-part distal radius dorsal Accu-Lock standard plate with EPL transposition and excision posterior interosseous nerve."[5]

In a November 11, 2014 attending physician's report (Form CA-16, Part B), Dr. Lourie diagnosed employment-related left distal radius fracture (ICD-9 813.42). He also noted appellant's October 22, 2014 surgery, and advised that she was able to return to work with restrictions as of November 6, 2014.

By decision dated November 25, 2014, OWCP denied appellant's traumatic injury claim because the evidence was insufficient to establish that her "medical condition [was] causally related to the accepted work event(s)."

On May 18, 2015 appellant timely requested reconsideration. OWCP received duplicate copies of the September 30 and October 2, 2014 CMC treatment records, as well as Dr. Lourie's treatment notes and his November 11, 2014 report. Additionally, it received a September 30, 2014 CMC transfer request form that included a diagnosis of nondisplaced left radius fracture. The reported reason for the transfer to AMC was "higher level of care." Appellant also submitted her September 30, 2014 discharge instructions from AMC, where she was seen by Dr. Ivan Cazort, who diagnosed distal radius (Colles) fracture. Dr. Cazort is Board-certified in emergency medicine.

Due to a prior work-related injury (OWCP File No. xxxxxx258), appellant had been working in a limited-duty capacity as a sales solution team member. She subsequently filed a separate occupational disease claim (Form CA-2) for a left upper extremity injury claim number (OWCP File No. xxxxxx135) that allegedly arose on or about September 30, 2014. Since the November 25, 2014 OWCP decision, appellant submitted a December 11, 2014 medical report regarding a separate September 30, 2014 left wrist and shoulder occupational disease claim number (xxxxxx135).

Additionally, OWCP received a February 10, 2015 duty status report (Form CA-17) which included diagnoses of cervical radiculitis and forearm joint pain (ICD-9 723.4 and 719.43, respectively). Dr. Srihari R. Malempati, a Board-certified general surgeon, examined appellant on December 11, 2014 and diagnosed left shoulder and left wrist sprains, which he attributed to her "work doing data entry and making [tele]phone calls…." The February 10, 2015 duty status report similarly attributed appellant's diagnoses to making "customer calls … and performing data entry…."[6]

By decision dated June 24, 2015, OWCP reviewed the merits of appellant's traumatic injury claim, but denied modification of its November 25, 2014 decision. It continued to find that appellant had not established a causal relationship between her September 30, 2014 work-related fall and her diagnosed left distal radius fracture.

[5] The October 22, 2014 operative report is not part of the current record.

[6] It is unclear who authored the February 10, 2015 Form CA-17.

LEGAL PRECEDENT

A claimant seeking benefits under FECA has the burden of establishing the essential elements of his or 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 determine if an employee sustained a traumatic 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 that must be considered in conjunction with one another. The first component is whether the employee actually experienced the employment incident that allegedly occurred.[8] The second component is whether the employment incident caused a personal injury.[9] An employee may establish that an injury occurred in the performance of duty as alleged, but fail to establish that the disability or specific condition for which compensation is being claimed is causally related to the injury.[10]

Causal relationship is a medical question that generally requires rationalized medical opinion evidence to resolve the issue.[11] However, in clear-cut traumatic injury claims, where the fact of injury is established and is clearly competent to cause the condition described (for instance, a worker falls from a scaffold and breaks an arm), a fully rationalized medical opinion is not needed.[12] The physician's diagnosis and an affirmative statement are sufficient to accept the claim.[13]

Certain healthcare providers such as physician assistants, nurse practitioners, physical therapists, and social workers are not considered "physician[s]" as defined under FECA.[14] Consequently, their medical findings and/or opinions will not suffice for purposes of establishing

[7] 20 C.F.R. § 10.115(e), (f); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996).

[8] *Elaine Pendleton*, 40 ECAB 1143 (1989).

[9] *John J. Carlone*, 41 ECAB 354 (1989). A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factor(s) 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 factor(s). *Id.*

[10] *Shirley A. Temple*, 48 ECAB 404, 407 (1997).

[11] *Robert G. Morris*, 48 ECAB 238 (1996).

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3d(1) (January 2013).

[13] *Id.*

[14] 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t).

entitlement to FECA benefits.[15] A report from a physician assistant or certified nurse practitioner will be considered medical evidence if countersigned by a qualified physician.[16]

A medical report should bear the physician's signature or signature stamp.[17] OWCP may require an original signature on the report.[18]

ANALYSIS

Appellant indicated that, while walking in the employee parking lot, she fell forward and hit the ground with her left hand extended outward. Ms. Williams, who was with appellant at the time, helped her up and noted that appellant was holding her left hand. By the time they returned to the building, appellant's hand had begun to swell. Ms. Williams reported the incident to her supervisor, Ms. Daniel, and afterwards Ms. Daniel accompanied appellant to CMC's urgent care facility for treatment. The September 30, 2014 Form CA-16 authorizing medical treatment noted that appellant "Fell and hurt left arm." Left hand/wrist/forearm x-rays obtained at CMC and AMC revealed a distal radius fracture. A contemporaneous left wrist CT scan confirmed the presence of a distal radius fracture, as noted by Dr. Johnson, a Board-certified diagnostic radiologist. OWCP denied appellant's traumatic injury claim on the basis that she failed to establish a causal relationship between her diagnosed left distal radius fracture and the accepted September 30, 2014 employment incident.

Rationalized medical opinion evidence is generally required to resolve the issue of causal relationship.[19] However, in clear-cut traumatic injury claims, where the fact of injury is established and is clearly competent to cause the condition described -- "for instance, a worker falls from a scaffold and breaks an arm" -- a fully rationalized medical opinion is not needed.[20] The physician's diagnosis and an affirmative statement are sufficient to accept the claim.[21]

As noted, the employing establishment authorized appellant's initial medical treatment on September 30, 2014, and Ms. Daniel accompanied her to an urgent care facility (CMC) where a physician assistant provided medical treatment. The September 30, 2014 CMC treatment records noted that appellant tripped and fell while walking through the parking lot, and that she landed on her left side, injuring her left wrist and hand. The physician assistant who treated appellant diagnosed closed fracture of the left distal radius. However, a physician assistant is not

[15] *K.W.*, 59 ECAB 271, 279 (2007); *David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006).

[16] *Supra* note 12 at Chapter 2.805.3a(1).

[17] 20 C.F.R. § 10.331(a).

[18] *Id.*

[19] *Robert G. Morris*, *supra* note 11.

[20] *Supra* note 12 at Chapter 2.805.3d(1).

[21] *Id.*

considered a "physician" as defined under FECA.[22] OWCP correctly noted this in its June 24, 2015 decision.

Appellant was later transferred to AMC's emergency department for a more extensive workup. The AMC records include multiple left upper extremity x-rays, a CT scan, and a discharge summary with a diagnosis of distal radius (Colles) fracture. The AMC diagnostic studies note a history of "Injury" or "Wrist injury" without elaboration and the AMC discharge instructions offer no information regarding the cause of appellant's Colles fracture. The AMC records provided thus far are insufficient to establish causal relationship.

Appellant returned to CMC's urgent care facility on October 2, 2014, where she was treated by another physician assistant, Annette S. Williams.[23]

Dr. Lourie first examined appellant on October 14, 2014 and performed left wrist surgery on October 22, 2014.[24] When he initially examined appellant, Dr. Lourie noted that she had sustained a hyperdorsiflexion injury to her left wrist on September 30, 2014. However, he did not indicate what appellant was doing at the time of her injury or further provide any rationalized medical evidence tying the September 30, 2014 incident to the diagnosed condition. Dr. Lourie's subsequent treatment notes from October 17, 22, and 23, and November 4, 2014 are similarly devoid of any explanation regarding the cause of appellant's September 30, 2014 left wrist condition.

Dr. Lourie's November 11, 2014 attending physician's report (Form CA-16, Part B) noted a history of left distal radius fracture, but did not otherwise describe how the injury occurred. He checked a box marked "yes" on the Form CA-16 indicating that he believed appellant's condition was caused or aggravated by an employment activity. However, Dr. Lourie did not provide an explanation. Merely placing a checkmark, without rationale will not suffice for purposes of establishing causal relationship.[25]

Although a Colles fracture is consistent with Dr. Lourie's mention of a hyper-dorsiflexion injury, currently there is a paucity of competent medical evidence linking appellant's left wrist diagnosis to the September 30, 2014 employee parking lot incident where she stumbled, fell forward, and hit the ground with her left hand extended outward. This injury is not one which meets the factual basis for a "clear-cut traumatic injury." Although there was swelling, no fracture was diagnosed until after x-rays were taken.[26] Accordingly, the Board finds that appellant failed to establish causal relationship.

[22] 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t). A report from a physician assistant will be considered medical evidence if countersigned by a qualified physician. *Supra* note 18.

[23] The October 2, 2014 CMC progress notes were similarly unsigned.

[24] As previously noted, the operative report is not part of the current record.

[25] *See D.D.*, 57 ECAB 734, 739 (2006); *Deborah L. Beatty*, 54 ECAB 340, 341 (2003).

[26] *Supra* note 12.

CONCLUSION

Appellant failed to establish that her closed fracture of the left distal radius is causally related to the September 30, 2014 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the June 24, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 5, 2016
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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