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

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| **D.A., Appellant** | ) | |
| **and** | ) | **Docket No. 16-0879** |
| | ) | **Issued: October 27, 2016** |
| **DEPARTMENT OF VETERANS AFFAIRS, VETERANS AMINISTRATION MEDICAL CENTER, Detroit, MI, Employer** | ) | |

*Appearances:*
*Alan J. Shapiro, Esq.*, for the appellant[1]
*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 23, 2016 appellant, through counsel, filed a timely appeal of a January 29, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

## ***ISSUE***

The issue is whether appellant met his burden of proof to establish an injury causally related to the accepted February 26, 2014 employment incident.

## ***FACTUAL HISTORY***

On March 5, 2014 appellant, then a 44-year-old motor vehicle operator, filed a traumatic injury claim (Form CA-1) alleging that on February 26, 2014 he strained his left shoulder when he lifted a heavy, oversized walker into a van. He stopped work on March 4, 2014.

In a February 26, 2014 incident report, appellant's supervisor indicated that on that day at around 1:00 p.m. appellant was getting ready to drive a patient home. When appellant lifted an oversized walker into the back of the van, he strained his shoulder. The supervisor noted that appellant returned to work with restrictions of no lifting.

Appellant was examined in employee health by Thresiamma Idichandy, a nurse practitioner, and Dr. Sudhir G. Rao, a Board-certified internist. In a February 27, 2014 progress note, Dr. Rao indicated that appellant complained of left shoulder pain since February 26, 2014 when he lifted a male patient's walker while transporting the patient. Physical examination revealed tenderness on the posterior part of appellant's left shoulder and limited range of motion. Dr. Rao reported no redness, swelling, or bruising. He authorized appellant to return to work with restrictions of no pulling, pushing, or lifting with his left hand until March 3, 2014.

Dr. Frances Hewitt, Board-certified in family medicine, also treated appellant. In a February 28, 2014 progress note, he noted a diagnosis of shoulder pain. In a March 4, 2014, report, Dr. Hewitt recommended that appellant remain off work from March 4 to 11, 2014.

Appellant underwent various diagnostic examinations. In a March 6, 2014 magnetic resonance imaging (MRI) scan examination report of the left shoulder, Dr. Marnix Van Holsbeeck, a diagnostic radiology specialist, observed arthritic changes of the left acromioclavicular (AC) joint, bone spurring of the proximal left humerus, and narrowing of the inferior left glenohumeral joint. He diagnosed sequelae of Bankart repair with arthritic change of the left glenohumeral.

In a March 6, 2014 ultrasound report of the left shoulder, Dr. Mark Diamond, a Board-certified diagnostic radiologist, observed that appellant's AC joint was within normal limits and supraspinatus and infraspinatus tendons were intact. He reported that appellant's subscapularis tendon was suboptimally visualized due to appellant's inability to externally rotate. Dr. Diamond noted that there was no evidence of rotator cuff tear, mass lesion, or glenohumeral joint effusion.

Dr. Joseph Hoegler, a Board-certified orthopedic surgeon, reported in a March 7, 2014 work status note that appellant should be off work until April 3, 2014.

Appellant received treatment from Dr. Nancy S. White, Board-certified in family and sports medicine. In a March 31, 2014 progress report, Dr. White opined that he should remain off work until April 18, 2014. She described that on February 26, 2014 appellant was helping a

300-plus pound patient into a car and experienced a pulling sensation in his left scapular region. Dr. White noted that he continued to complain of left posterior shoulder pain. She reviewed appellant's history and noted that an ultrasound report showed no evidence of rotator cuff tear or supraspinatus muscular tear. Upon examination, Dr. White observed slight tenderness in the midline of the lower cervical segment and extreme tenderness in the left superior trapezius region. Forward flexion, extension, right and left side bending, and right and left lateral rotation were normal. Hawkins and Neer impingement signs were positive. Dr. White diagnosed persistent left posterior shoulder pain, likely cervical radiculitis.

In a letter dated April 21, 2014 a human resource (HR) specialist at the employing establishment, noted that the medical evidence revealed that appellant was temporarily unable to perform his normal duties, but that he was physically able to perform alternative duty tasks. She offered him an alternative-duty assignment in the Motor Vehicle Section of the Police and Security Service. The HR specialist advised appellant that if he was unable to perform the alternative duties he must provide medical evidence to support his inability to perform the alternative duty.

Dr. White continued to treat appellant and in an April 21, 2014 report advised that he may return to work on April 22, 2014 with restrictions of no lifting in excess of 15 pounds and minimal lifting above shoulder height. She recommended that the restrictions were effective until May 18, 2014.

On April 22, 2014 appellant filed a claim for wage-loss compensation (Form CA-7) for the period March 4 to April 21, 2014.

By letter dated April 29, 2014, OWCP informed appellant that his claim initially appeared to be a minor injury, but was now being reopened for review on the merits. It requested that he submit additional evidence to establish that he sustained a diagnosed condition causally related to the February 26, 2014 employment incident. Appellant was afforded 30 days to submit this additional evidence.

In a May 16, 2014 report, Dr. White indicated that she examined appellant and noted a diagnosis of osteoarthritis of left glenohumeral joint. She recommended that he work with restrictions of no lifting in excess of 15 pounds and minimal work or lifting above shoulder height. Dr. White noted that appellant's restrictions were effective from April 21 to May 18, 2014.

OWCP denied appellant's claim in a decision dated May 29, 2014. It accepted that the February 26, 2014 incident occurred as alleged and that he sustained a left shoulder condition, but denied his claim finding that the medical evidence was insufficient to establish that his condition was causally related to the accepted incident.

Following OWCP's denial decision, appellant submitted a June 13, 2014 report from Dr. White. Dr. White related that on February 26, 2014 he helped a male patient get into appellant's car with his seated walker and felt a pulling sensation in the left scapular region. She noted a diagnosis of osteoarthritis of the left glenohumeral joint. Upon examination, Dr. White observed slight tenderness in the midline of the lower cervical segment, extreme tenderness in

the left superior trapezius region, and limited range of motion. Hawkins and Neer impingement tests were positive. Dr. White also noted pain on each of the tests along the spine of appellant's left scapula. She reviewed his diagnostic examination results and noted that it revealed moderate glenohumeral arthritis and rotator cuff tendinosis. Dr. White explained that it was clear that appellant had underlying left shoulder pathology with glenohumeral osteoarthritis and rotator cuff tendinosis. She opined that any repetitive lifting or working above the shoulder height would aggravate this issue.

On July 8, 2014 OWCP received appellant's appeal request form, postmarked July 1, 2014, which requested a review of the written record by an OWCP hearing representative.

By decision dated July 18, 2014, OWCP denied appellant's request for review of the written record. It determined that his request was not made within 30 days of the May 29, 2014 OWCP decision and that his case could equally well be addressed by requesting reconsideration.

On December 10, 2014 OWCP received appellant's request, through counsel, for reconsideration of the May 29, 2014 OWCP decision.

By decision dated December 16, 2014, OWCP denied modification of the May 29, 2014 decision. It found that the new medical report from Dr. White failed to establish causal relationship.

On November 16, 2015 OWCP received appellant's request, through counsel, for reconsideration. Appellant resubmitted Dr. White's April 21, May 16, and June 13, 2014 reports; and March 6, 2014 diagnostic testing reports. He also submitted several physical therapy reports dated March 18 and 24, 2014.

Appellant also submitted a March 6, 2014 narrative report from Dr. Hewitt who examined him for complaints of left shoulder pain. Dr. Hewitt related that appellant noted his current episode of left shoulder pain started one to four weeks ago and had gradually worsened. He noted that appellant had a history of osteoarthritis. Dr. Hewitt recounted that on February 26, 2014 appellant was helping a 340-pound plus male patient get into a van with a seated walker when he felt a pull in the left shoulder. He discussed appellant's history and conducted an examination. Dr. Hewitt observed normal range of motion, mood, affect, and behavior.

Dr. White continued to treat appellant and indicated in a September 25, 2015 narrative report that he suffered a left shoulder injury in February 2014 when he assisted a large man who was falling. She noted that he experienced limited motion and weakness at the onset of that injury. Dr. White reported that appellant had surgery in the remote past, but was without shoulder complaints until this injury occurred in 2014. She opined that at this point he needed arthroscopic debridement and decompression.

By decision dated January 29, 2016, OWCP denied modification of the December 16, 2014 decision. The decision noted that because Dr. White provided an inaccurate description of the February 26, 2014 employment incident, her report was of insufficient probative value to alter OWCP's denial decision.

## ***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 submit sufficient evidence to establish that he or 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 his or 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]

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[3] *Id*.

[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).

[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).

## ***ANALYSIS***

Appellant alleged that on February 26, 2014 he strained his left shoulder in the performance of duty. On May 29 2014 OWCP accepted that the employment incident occurred as alleged and that he was diagnosed with left shoulder osteoarthritis. However, it denied appellant's claim finding that the medical evidence of record was insufficient to establish that his left shoulder condition was causally related to the February 26, 2014 employment incident. The Board finds that he has failed to establish that his left shoulder condition resulted from the accepted incident.

Appellant initially received medical treatment in the employee health unit. In a February 27, 2014 progress note, Dr. Rao described that on February 26, 2014 appellant experienced left shoulder pain when he helped transport a patient and lifted a patient's walker. He provided physical examination findings and authorized appellant to return to work with restrictions. The Board finds that Dr. Rao's report is insufficient to establish appellant's claim as he did not provide a medical diagnosis, nor did he provide an opinion as to whether the February 26, 2014 employment incident caused or contributed to appellant's alleged condition.[13] He merely described the employment incident and noted examination findings.

Similarly, Dr. Hewitt's February 28, 2014 progress note and March 6, 2014 narrative report and Dr. Hoegler's March 7, 2014 work status note did not offer any medical diagnosis or explanation of the cause of appellant's left shoulder pain. These reports, therefore, fail to establish appellant's claim.[14]

Appellant was treated by Dr. White who provided reports dated March 31, 2014 to September 25, 2015. Dr. White initially described that on February 26, 2014 he helped a 300-plus pound patient into a car and experienced a pulling sensation in his left scapular region when he lifted an oversized walker into the car. She reviewed appellant's diagnostic examination reports and noted that they revealed moderate glenohumeral arthritis and rotator cuff tendinosis, but showed no evidence of rotator cuff tear or supraspinatus muscular tear in appellant's left shoulder. Upon examination, Dr. White observed slight tenderness in the midline of the lower cervical segment and extreme tenderness in the left superior trapezius region. Range of motion was limited. In a May 16, 2014 report, Dr. White related that she examined appellant and diagnosed osteoarthritis of left glenohumeral joint. In a June 13, 2014 report, she explained that it was clear that he had underlying left shoulder pathology with glenohumeral osteoarthritis and rotator cuff tendinosis.

Although Dr. White mentioned the February 26, 2014 work incident and diagnosed left shoulder osteoarthritis head trauma, she did not clearly opine, nor explain, how the February 26, 2014 incident caused or contributed to appellant's left shoulder injury. The Board has held that medical evidence that does not offer any opinion regarding the cause of an employee's condition

[13] *Roy L. Humphrey*, 57 ECAB 238, 242 (2005); *Michael E. Smith*, 50 ECAB 313 (1999).

[14] *Id.*

is of limited probative value on the issue of causal relationship.[15] Moreover, the Board notes that Dr. White fails to provide an accurate history of injury. In a September 25, 2015 narrative report, she recounted that in February 2014 appellant sustained a left shoulder injury when he assisted a large man who was falling. The Board has held that medical reports must be based on a complete and accurate factual and medical background.[16] Because Dr. White provided two different accounts of the February 26, 2014 employment incident, her report is of limited probative value to establish appellant's claim.

The additional diagnostic examination reports are insufficient to establish appellant's claim. In a March 6, 2014 MRI scan examination report of his left shoulder, Dr. Van Holsbeeck noted sequelae of Bankart repair with arthritic change of the left glenohumeral joint. In a March 6, 2014 ultrasound examination report, Dr. Diamond observed that appellant's AC joint was within normal limits and supraspinatus and infraspinatus tendons were intact. He noted no evidence of rotator cuff tear, mass lesion, or glenohumeral joint effusion. None of the physicians provided any opinion on the cause of appellant's left shoulder condition.[17]

On appeal, counsel asserts that OWCP's January 29, 2016 decision was contrary to law and fact. As explained above, however, none of the evidence of record established that appellant sustained a left shoulder condition as a result of the February 26, 2014 employment incident. Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[18] Because appellant has failed to provide such rationalized medical opinion evidence in this case, the Board finds that he has not met his 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 his burden of proof to establish an injury causally related to the February 26, 2014 employment incident.

[15] *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *J.F.*, Docket No. 09-1061 (issued November 17, 2009); *A.D.*, 58 ECAB 149 (2006).

[16] *J.R.*, Docket No. 12-1099 (issued November 7, 2012); *Douglas M. McQuaid*, 52 ECAB 382 (2001).

[17] The record also contains a March 17, 2015 work status note by a physician with an illegible signature. Because reports that are unsigned or bear illegible signatures are not considered probative medical evidence, this work status note fails to establish appellant's claim. *Thomas L. Agee*, 56 ECAB 465 (2005); *Richard F. Williams*, 55 ECAB 343 (2004).

[18] *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *D.I.*, 59 ECAB 158 (2007).

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the January 29, 2016 merit decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 27, 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