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

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| **T.S., Appellant** | ) | |
| **and** | ) | **Docket No. 17-0779** |
| | ) | **Issued: December 11, 2017** |
| **DEPARTMENT OF THE ARMY, AVIATION & MISSILE COMMAND, Corpus Christi, TX, 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
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

### ***JURISDICTION***

On February 24, 2017 appellant, through counsel, filed a timely appeal from a December 20, 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 occupational disease causally related to accepted factors of his federal employment.

## ***FACTUAL HISTORY***

On August 8, 2014 appellant, then a 58-year-old aircraft mechanical parts repairer, filed an occupational disease claim (Form CA-2) alleging that he was having difficulty grasping items at work. He explained that his physician suspected he was dropping his tools and parts at work due to carpal tunnel syndrome. Appellant indicated that he first became aware of his claimed condition and realized that it resulted from his federal employment on March 18, 2013. He did not stop work. Appellant also noted that he had previously sustained a neck injury on November 28, 2006.[3] The employing establishment reported that appellant would be temporarily accommodated performing light-duty tasks.

Appellant provided a position description for an aircraft mechanical parts repairer, a detailed list of his employment duties as of 1975, and medical reports regarding treatment for his November 28, 2006 work-related neck injury.

Dr. Paxton J. Longwell, a Board-certified neurologist, conducted an electromyography and nerve conduction velocity (EMG/NCV) study of appellant's upper extremities and in a March 25, 2014 report noted that appellant worked as a helicopter mechanic. He related appellant's complaints of neck and bilateral hand pain and of weakness and numbness in both hands. Dr. Longwell indicated that examination revealed normal and symmetrical deep tendon reflexes (DTR). Tinel's sign of both wrists were positive. Dr. Longwell reported that the EMG/NCV study of the upper extremities showed significant compressive neuropathies of the bilateral median nerves at the wrist, *i.e.*, moderately-severe bilateral carpal tunnel syndrome. He noted no evidence of cervical radiculopathy, brachial plexopathy, or more proximal entrapment neuropathy.

On May 6, 2014 appellant underwent cervical fusion surgery. In hospital records dated May 6 and 7, 2014, Dr. Smith noted a diagnosis of acute cervical radiculopathy. He recommended pain medication and provided discharge instructions.

In a May 24, 2014 hospital record, Dr. Antonio Lykos, an osteopath specializing in family medicine, related appellant's complaints of headache and neck pain. He noted appellant's history of a slip and fall and status post cervical fusion. Examination of appellant's neck revealed tenderness and decreased range of motion. Dr. Lykos reported a negative cervical spine computerized tomography (CT) scan. He diagnosed forehead hematoma and acute cervical spine strain and provided discharge instructions.

[3] The record reveals that appellant had a previously accepted traumatic injury claim OWCP File No. xxxxxx207 for neck sprain and brachial neuritis or radiculopathy occurring on November 28, 2006. Appellant received schedule award benefits for this injury from November 4 2011 until September 4, 2012. He also received compensation benefits on the periodic rolls from May 6 until July 1, 2014 and on the supplemental rolls from November 4, 2014 through January 7, 2015.

In a May 24, 2014 cervical spine CT scan report, Dr. Kenneth Cook, a Board-certified radiologist, noted no acute abnormalities. He also observed an intact previous surgery for C4-6 degenerative disease. In a May 24, 2014 head and brain CT scan report, Dr. Cook indicated a negative CT of the brain.

Dr. Smith completed a June 27, 2014 work capacity evaluation (Form OWCP-5c) in which he checked a box marked "No" indicating that appellant was not capable of performing his usual job. He noted that appellant could work with restrictions of no reaching, twisting, pushing, pulling, lifting, squatting, kneeling, and climbing.

In a July 8, 2014 Form OWCP-5c, Dr. Pendleton indicated that appellant was capable of working with restrictions of no reaching, reaching above the shoulder, twisting, bending/stooping, pushing, pulling, lifting, squatting, kneeling, and climbing. He noted that appellant was status post anterior cervical fusion surgery at C5-6 to C7.

Appellant indicated in an undated statement that he underwent pain management with Dr. Gabriel Lopez, a Board-certified anesthesiologist, for five years following his November 28, 2006 neck injury. He explained that in 2013, Dr. M.J. Pendleton, an internist, became his primary care physician and referred him to Dr. Howard Smith, a Board-certified neurosurgeon, who recommended diagnostic testing. Appellant explained that the results of the diagnostic testing revealed that he had a severe case of carpal tunnel syndrome and needed surgery. He noted that his condition would worsen if he kept using his hands and elbows. Appellant indicated that after the cervical surgery he still experienced grip numbness, tingling in both hands, and he continued to drop tools. Therefore he concluded that his neck injury caused the carpal tunnel syndrome.

The employing establishment informed appellant in a July 22, 2014 memorandum that he would be temporarily accommodated performing light-duty tasks. It described appellant's employment duties.

Dr. Smith continued to treat appellant. In a July 25, 2014 report, he noted that appellant was status post anterior cervical discectomy and fusion and still complained of a burning sensation to both shoulders and into the bilateral upper extremities. Dr. Smith described appellant's 2006 neck injury and the medical treatment he had received. He indicated that he reviewed a recent cervical spine magnetic resonance imaging (MRI) scan which showed a large disc herniation at C5-6 with signal changes in the cord on the T2 images and a right C6-7 disc herniation. Dr. Smith reported that an EMG/NCV study also revealed bilateral carpal tunnel syndrome. He related appellant's diagnoses of brachial neuritis, cervicalgia, and cervical spondylosis onset January 31, 2014 and carpal tunnel syndrome onset March 28, 2014. Upon physical examination of appellant's cervical spine, Dr. Smith noted that appellant's wound was well-healed and sensation was intact to light touch and pinprick. Strength was 5/5. Dr. Smith explained that he had expected appellant to be doing much better by this time and recommended physical therapy and a functional capacity evaluation (FCE). He provided a July 25, 2014 duty status report (Form CA-17) with appellant's work restrictions.

Appellant submitted a July 29, 2014 employing establishment health unit note by a physician assistant with an illegible signature which indicated that appellant could return to work with restrictions continuing for eight weeks.

In an August 8, 2014 statement, E.C., appellant's supervisor, reported that appellant worked in the UH-60 Transmission Assembly cost center and related that his duties as an aircraft mechanical parts repairer were to assemble and subassemble air force and army transmissions. He explained that appellant used his hands and wrist to turn wrenches and record information on all supporting documents. E.C. noted that he was unaware of appellant's carpal tunnel syndrome resulting from the prior November 28, 2006 injury. He related that, since becoming appellant's supervisor, appellant had not complained about the condition to him or use any leave due to a carpal tunnel problem. E.C. indicated that he was not informed of appellant's carpal tunnel syndrome until July 22, 2014 when appellant asked for assistance to fill out a Form CA-2. He reported that appellant was temporarily accommodated beginning July 22, 2014 to perform light-duty tasks.

Appellant submitted a September 5, 2014 FCE report by Maria Chavez, a physical therapist, who concluded that appellant was capable of performing light to medium work.

On September 23, 2014 appellant filed a claim for a schedule award (Form CA-7).

In a November 8, 2014 handwritten statement, appellant related that on October 27, 2014 he was working on a UH-60 main transmission and started to break torque when he felt a bone or muscle move. He indicated that he felt back pain and neck stiffness when he turned to the left or right. Appellant reported the injury and went to the blue room where emergency medical services (EMS) were called. He related that when EMS arrived they informed him that his vitals were high. Appellant explained that he returned to work because his supervisor told him that the work excuse from his doctor did not sufficiently explain the duties that he could not perform. He noted that when he went to see Dr. Pendleton on November 4, 2014, Dr. Pendleton advised him to consider medical disability retirement. Appellant indicated that the employing establishment continued to instruct him to go to work because his medical documents were not sufficient to excuse him from work.

In a letter dated November 21, 2014, OWCP advised appellant that the evidence submitted was insufficient to establish his occupational disease claim. It requested that he complete the attached development questionnaire to substantiate the factual elements of his claim and provide medical evidence to establish a diagnosed condition as a result of his federal employment. Appellant was afforded 30 days to submit the requested information.

Dr. Smith noted in a December 1, 2014 report that appellant remained under his care. He indicated that appellant was informed not to return to work from October 29 to November 26, 2014. Dr. Smith related that when appellant returned for a follow-up visit, he then took appellant off work for an additional six weeks.

In a December 13, 2014 handwritten statement, appellant clarified that when he returned to work on December 18, 2006 he worked regular duty. He noted that he did not work light duty until after he stopped work from March 23 to July 21, 2013. Appellant explained that he then

worked limited duty for two weeks before returning to full duty. He alleged that during the time period of working regular duty from August 23, 2013 to April 11, 2014 he complained of not being able to hold and grab his tools, losing strength in his upper body to his fingers, and numbness and tingling in both his hands and fingers. Appellant also provided a handwritten job description of his duties.

By letter dated December 14, 2014, appellant informed OWCP that Dr. Smith would be performing a medical procedure for his carpal tunnel syndrome. He noted that he would send OWCP a copy of the medical evaluation.

In a December 16, 2014 letter, T.H., chief of the PSA Frontend Division of the employing establishment, informed appellant that his request for FMLA leave until December 24, 2014 due to his serious health condition was approved. He noted that appellant was on LWOP status that began on November 24, 2014.

OWCP denied appellant's claim in a decision dated January 14, 2015. It accepted appellant's employment duties as an aircraft mechanical parts repairer, but denied the claim because the medical evidence of record was insufficient to establish a diagnosed medical condition causally related to the accepted employment factors.

On January 22, 2015 appellant, through counsel, requested a telephonic hearing before an OWCP hearing representative. On July 13, 2015 a telephonic hearing was held. Appellant related that Dr. Wilson was the first doctor who noticed his carpal tunnel syndrome. He noted that Dr. Smith performed neck surgery on him and also explained in his report how appellant developed carpal tunnel syndrome. Appellant related that he still experienced numbness in his hands and difficulty grasping objects. He noted that he still worked full time.

In a decision dated September 29, 2015, an OWCP hearing representative affirmed the January 14, 2015 OWCP decision. She determined that the medical evidence of record demonstrated that appellant was diagnosed with carpal tunnel syndrome, but found that it failed to establish that his medical condition was causally related to his repetitive employment duties.

On September 21, 2016 appellant, through counsel, requested reconsideration. He indicated that he was submitting various medical documents that were not previously considered.

Appellant resubmitted Dr. Longwell's March 25, 2014 EMG/NCV study report, the July 24, 2014 employing establishment health unit note with an illegible signature, and the employing establishment's December 23, 2014 letter. He also submitted additional employee health notes dated July 24, 2013 to July 9, 2014 regarding various accidents and injuries that appellant had experienced at work.

In an April 2, 2014 work release and hospital note, Dr. Alainya Tomanec, an anesthesiologist, indicated that appellant was seen in the emergency department on April 2, 2014. She noted a diagnosis of cervical radiculopathy. Dr. Tomanec opined that appellant may return to work with restrictions on April 3, 2014. In the margins of the report, appellant indicated that he had to return to work in April 2014 because his supervisor told him that he would be put in LWOP status.

Appellant also submitted a description of his work duties and the movements he performed in the disassembly area of his shop. He indicated that the physical requirements of his job included pushing and pulling for 30 minutes on a cart, many times on wrenches and torque wrenches per hour, walking for one hour, standing, sitting, and examining for five to six hours.

In a February 10, 2015 letter, Dr. Pendleton noted that appellant was seen in his office on January 29, 2015. He related that based on physical evaluation and discussion with appellant's psychiatrist, appellant could return to sedentary work-related duties.

By decision dated December 20, 2016, OWCP denied modification of the September 29, 2015 decision. It found that the medical evidence of record was insufficient to establish that appellant's carpal tunnel syndrome was causally related to his employment.

## ***LEGAL PRECEDENT***

An employee seeking benefits under FECA[4] 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[5] 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.[6] In an occupational disease claim, appellant's burden requires submission of the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[7]

Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.[8] 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.[9]

## ***ANALYSIS***

Appellant alleges that he sustained carpal tunnel syndrome as a result of his repetitive duties as an aircraft mechanical parts repairer. OWCP accepted appellant's repetitive job duties

[4] *Supra* note 2.

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

[6] *M.M.*, Docket No. 08-1510 (issued November 25, 2010); *G.T.*, 59 ECAB 447 (2008); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[7] *R.H.*, 59 ECAB 382 (2008); *Ernest St. Pierre*, 51 ECAB 623 (2000).

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

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

and that he was diagnosed with bilateral carpal tunnel syndrome. However, it denied his claim because the medical evidence submitted failed to establish that his bilateral carpal tunnel syndrome was causally related to his employment. The Board finds that appellant has not met his burden of proof to establish his occupational disease claim.

Appellant was primarily treated by Dr. Smith. In hospital records dated May 6 and 7, 2014, he noted a diagnosis of cervical radiculopathy. In a July 25, 2014 narrative report, Dr. Smith described appellant's 2006 cervical injury and the subsequent medical treatment he had received. He reported on July 25, 2014 that an EMG/NCV study revealed bilateral carpal tunnel syndrome. Dr. Smith provided physical examination findings and noted diagnoses of brachial neuritis, cervicalgia, and cervical spondylosis onset January 31, 2014 and carpal tunnel syndrome onset March 28, 2014. He indicated that appellant could work with restrictions. The Board notes that Dr. Smith did not provide an opinion on the cause of appellant's diagnosed conditions. The Board has held 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.[10] Dr. Smith did not opine or explain how appellant's employment duties as an aircraft mechanic caused or contributed to his carpal tunnel syndrome. Likewise, Dr. Lykos' May 29, 2014 hospital record and Dr. Tomanec's April 2, 2014 note related diagnoses of forehead hematoma, acute cervical spine strain and cervical radiculopathy, but did not provide an opinion relating the cause of these diagnosed conditions. As such these reports are of limited probative value regarding the issue of causal relationship.[11]

Similarly, the diagnostic reports, including Dr. Longwell's March 25, 2014 EMG/NCV study report and Dr. Cook's May 24, 2014 cervical spine CT scan report also provided a medical diagnosis, but no opinion on the cause of the condition.[12] These reports, therefore, are also insufficient to establish appellant's claim.

Appellant provided medical reports by Dr. Pendleton who noted in a July 8, 2014 Form OWCP-5c that appellant was status post anterior cervical fusion surgery at C5-6 to C-7 and was able to work with restrictions. In a February 10, 2015 letter, he authorized appellant to return to sedentary work-related duties. Dr. Pendleton, however, did not provide any medical diagnosis, other than being post anterior cervical fusion surgery. Accordingly, the Board finds that his medical reports lack probative value because he failed to provide a firm, medical diagnosis, or any explanation as to the cause of appellant's alleged condition.[13]

The additional employing establishment health unit note by a physician assistant and the physical therapist's notes also lack probative value. Healthcare providers such as physician

[10] *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).

[11] *Id*.

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

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

assistants, physical therapists**,** or nurse practitioners, are not considered physicians as defined under FECA.[14]

The mere fact that work activities may produce symptoms revelatory of an underlying condition does not raise an inference of an employment relation.[15] Such a relationship must be shown by rationalized medical evidence of causal relation based upon a specific and accurate history of employment conditions which are alleged to have caused or exacerbated a disabling condition.[16] Because appellant has not submitted such rationalized medical evidence in this case, the Board finds that he has not met his burden of proof to establish his occupational disease 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 has not met his burden of proof to establish an occupational disease causally related to accepted factors of his federal employment.

[14] The term physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. *See* 5 U.S.C. § 8102(2); *David P. Sawchuk*, 57 ECAB 316 (2006) (lay individuals such as nurses, physician assistants and physical therapists are not competent to render a medical opinion under FECA). *See also M.M.*, Docket No. 16-1617 (issued January 24, 2017).

[15] *See D.R.*, Docket No. 16-0528 (issued August 24, 2016).

[16] *Patricia J. Bolleter*, 40 ECAB 373 (1988).

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the December 20, 2016 decision of the Office of Workers' Compensation Programs is affirmed.[17]

Issued: December 11, 2017
Washington, DC

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

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

[17] Colleen Duffy Kiko, Judge, participated in the original decision but was no longer a member of the Board effective December 11, 2017.