United States Department of Labor
Employees' Compensation Appeals Board

S.C., Appellant	)	
and	)	**Docket No. 16-1322**
	)	**Issued: January 18, 2017**
DEPARTMENT OF VETERANS AFFAIRS, CENTRAL ARKANSAS HEALTHCARE SYSTEM, Little Rock, AK, 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:
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 13, 2016 appellant, through counsel, filed a timely appeal from the April 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 her burden of proof to establish a right arm injury causally related to the accepted June 12, 2013 employment incident.

FACTUAL HISTORY

On September 17, 2014 appellant, then a 42-year-old medical instrument technician filed a traumatic injury claim (Form CA-1) alleging that on June 12, 2013 she sprained her right wrist during a cardiopulmonary resuscitation (CPR) instructor class, and that the sprain evolved into reflex sympathetic dystrophy and now included her right hand and arm. The claim form did not indicate that she stopped work.

By letter dated September 30, 2014, the employing establishment controverted appellant's claim. It noted that the June 12, 2013 injury was not reported until September 17, 2014 and that no medical documentation had been provided to establish causal relationship.

By letter to appellant dated October 9, 2014, OWCP indicated that further information, including medical evidence, was necessary to support appellant's claim. Appellant was afforded 30 days to submit this information.

Appellant submitted statements by two colleagues, L.G. and M.W. She also responded to OWCP's questions, noting that, at the time of her injury, she was in a CPR instructor class on the campus of the employing establishment. Appellant added that the immediate effects of her injury were weakness in her right wrist with a bit of sharp pain when she moved it forward and backward. She also noted that by the time she got to her car her right wrist was swollen, so she went home and used ice packs, wrapped it in an ace bandage, elevated it, and took some ibuprofen.

Appellant received treatment from numerous physicians and other healthcare personnel at the University of Arkansas Hospital. In an August 23, 2013 imaging report of appellant's right hand, Dr. John Lofton Wilson, an orthopedic surgeon, found no evidence of fracture or dislocation. In a September 11, 2013 report, Dr. Marcus M. Kessler, a Board-certified radiologist, noted a normal bone scintigraphy, with no scintigraphic findings suggestive of complex regional pain syndrome. In a September 13, 2013 report, Dr. Deipti H. Trehun, a Board-certified family practitioner, listed medical history of decreased reflex, carpal tunnel syndrome on the right, and complex regional pain syndrome. An October 1, 2013 magnetic resonance imaging (MRI) scan with contrast of the brain was interpreted by Dr. Samant Rohan, a radiologist, as evidencing migrational anomaly with periventricular gray matter heterotopia that was also along the walls of the occipital horns. An October 23, 2013 MRI scan of the thoracic spine was interpreted by Dr. Ryan T. Fitzgerald, a Board-certified radiologist, as unremarkable.

In an October 29, 2013 report, Dr. Betul Melek Gundogdu, a Board-certified neurologist, stated that appellant presented with right elbow pain and sensory paresthesias in the right hand that started after three days of repetitive movements of right elbow and wrist. He noted that the examination findings suggested that she could possibly have right reflex sympathetic dystrophy.

Dr. Gundogdu indicated that appellant also had lower extremity symptoms, and that while some of her symptoms suggest complex regional pain syndrome, the diagnosis could not be confirmed. He noted that the initial problem started after a CPR course where she had to perform repetitive flexion movements with her elbow and wrists. Dr. Gundogdu, interpreted an October 30, 2013 electromyogram and never conduction velocity as normal, noting no findings to support upper extremity entrapment neuropathies or left lumbosacral radiculopathy. In a November 14, 2013 report, Dr. Thomas S. Kiser, a Board-certified physiatrist, noted that appellant had hand pain and paresthesia.

Appellant had numerous stellate ganglion blocks for treatment of her chronic regional pain syndrome in her right upper extremity, including injections given by Dr. Michael R. Stone, a Board-certified anesthesiologist, who submitted reports dated March 26, April 8, 11, and 21, and July 7 2014. In a June 6, 2014 report, Dr. Mohamed Tolba listed diagnoses of complex regional pain syndrome. On July 7, 2014 Dr. Luke N. Weiler, an anesthesiologist, added fibromyalgia to appellant's diagnosed conditions. In a July 8, 2014 report, Dr. Jamie D. Howard, a Board-certified family practitioner, noted that appellant had been fatigued for several months, and that her primary diagnosis was complex regional pain syndrome.

On September 11, 2014 Dr. Kessler reviewed a bone scan and noted normal bone scintigraphy, no scintigraphic findings suggestive of complex regional pain syndrome. Appellant received another injection by Dr. Adewumi O. Amole, a Board-certified radiologist on September 29, 2014.

In an October 30, 2014 attending physician's report (Form CA-20), Dr. Stone listed appellant's diagnosis as complex regional pain syndrome. He checked a box marked "yes" indicating that he believed that the condition was caused or aggravated by an employment activity, noting that her history started after CPR.

By decision dated January 12, 2015, OWCP denied appellant's claim. It determined that although she established that the incident occurred as alleged and that she suffered from complex regional pain syndrome, the evidence was insufficient to establish a causal relationship between her accepted June 12, 2013 incident at the CPR class and the accepted medical diagnosis of complex regional pain syndrome.

On April 17, 2015 appellant requested reconsideration. In support thereof, she submitted an April 14, 2015 letter, Dr. Stone stated that since he was not present at the CPR class and he did not see her until several weeks afterwards, all he could say was that the chronic regional pain syndrome type 1 was consistent with the injury and timing as she described it. He noted that the edema, allodynia, and color changes in the hand are consistent for an injury as subsequent to CPR by appellant. Appellant also submitted information from the internet on complex regional pain syndrome.

By decision dated April 29, 2015, OWCP reviewed appellant's case on the merits but denied modification of its January 12, 2015 decision. It noted the delay in the medical reports mentioning the accepted employment incident.

On January 12, 2015 appellant, through counsel, requested reconsideration. In support thereof, he submitted progress notes dated from February 11, 2015 from Dr. Majid Saleem, a physician Board-certified in anesthesiology and pain medicine. Dr. Saleem diagnosed reflex sympathetic dystrophy of the upper limb, unspecified myalgia and myositis, and chronic regional pain syndrome, and long-term use of other medications. He noted multiple stellate ganglion blocks had been administered without any significant relief. Dr. Saleem continued to treat appellant with pain medication, including repeat right, and left stellate ganglion blocks.

By decision dated April 29, 2016, OWCP found that the evidence was insufficient to modify the April 29, 2015 decision because the evidence of file was devoid of a thorough and rationalized physician's opinion that stated unequivocally that the traumatic work injury of June 12, 2013 resulted in the specific diagnosis of complex regional pain disorder.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] has the burden of establishing that 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 timely filed within the applicable time limitation period of FECA, that an injury was caused in the performance of duty as alleged, and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury.[4] 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.[5]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it must first be determined whether a fact of injury has been established. 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.[6] Second, the employee must submit sufficient evidence, generally only in the form of medical evidence, to establish that the employment incident caused a personal injury.[7]

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.[8] The weight of the medical evidence is determined by its reliability, its probative value, its convincing quality, the

[3] *Id.*

[4] *Joe D. Cameron*, 42 ECAB 153 (1989); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[5] *Victor J. Woodhams*, 41 ECAB 345 (1989).

[6] *John J. Carlone*, 41 ECAB 354 (1989).

[7] *Id.*

[8] *I.J.*, 59 ECAB 408 (2008); *supra* note 5.

care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[9]

ANALYSIS

The evidence establishes that the June 12, 2013 employment incident occurred as alleged, and that appellant suffers from numerous ailments, including complex regional pain syndrome. However, the Board finds that she has failed to establish a causal relationship between her accepted employment incident and her alleged medical condition.

Appellant submitted numerous reports from University of Arkansas Hospital. These reports list multiple ailments including, decreased reflex, weakness, paresthesia, carpal tunnel syndrome of the right, and in addition to complex regional pain syndrome. However, no physician provided a well-rationalized opinion explaining how appellant's complex regional pain syndrome was caused by the June 12, 2013 employment incident.[10]

Some of the hospital's medical reports discuss conditions other than appellant's complex regional pain syndrome, including the reports of Drs. Kessler, Rohan, and Weiler. Drs. Trehun, Amole, Howard, Tolba, Howard, Kiser, and Saleem, all discuss appellant's treatment for complex regional pain syndrome, but do not provide any opinion as to what caused this condition. Accordingly, these reports do not establish a causal relationship.[11]

The reports by the physicians interpreting diagnostic studies, including the reports from Drs. Wilson and Fitzgerald, also do not address the cause of any of the diagnosed conditions. As such these reports are of no probative value on the issue of whether any of appellant's medical diagnoses were causally related to the accepted employment incident.[12]

There is no mention of the work incident in any of the medical reports until the October 29, 2013 report by Dr. Gundogdu. In his October 29, 2013 report, Dr. Gundogdu indicates that "it looks like the problem started after a CPR course that she had to give and do repetitive flexion movements of her elbows and wrists." He does not provide any rationalized opinion on causal relationship; rather, he simply notes appellant's history and checked a box marked "yes" noting causal relationship. However, the Board has held that a report that addresses causal relationship with a checkmark, without medical rationale explaining how the work incident caused the alleged condition, is of diminished probative value and insufficient to establish causal relationship. Although Dr. Gundogdu provided a vague opinion in support of appellant's claim that her right arm condition was causally related to the accepted incident, his opinion on causal relationship was conclusory.[13]

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

[10] *Supra* note 8.

[11] *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

[12] *G.M.*, Docket No. 14-2057 (issued May 12, 2015).

[13] *L.N.*, Docket No. 16-0566 (issued October 18, 2016).

In an October 30, 2014 attending physician's report, Dr. Stone listed appellant's diagnosis of complex regional pain syndrome and also checked a box marked "yes" indicating that it was caused or aggravated by an employment activity, noting that appellant's history started after CPR. As previously noted, a medical report that addresses causal relationship with a check mark, without more in the way of medical rationale, is of limited probative value.[14]

In his April 14, 2015, report, Dr. Stone stated that since he was not present at the class and did not see appellant until several weeks later, all he could say was that the chronic regional pain syndrome she was experiencing was consistent with the injury and timing as she described it. Although this opinion from him is generally supportive of causal relationship, it did not provide adequate medical rationale explaining the basis of the opinion, nor explain the process by which appellant's CPR class caused or contributed to the diagnosed conditions or why the condition was not related to nonwork factors.[15] Furthermore, the Board finds Dr. Stone's opinions on causal relationship are speculative. The Board has held that speculative and equivocal medical opinions regarding causal relationship have no probative value.[16]

Finally, the Board notes that the statements by the lay witnesses are of no probative value. Because causal relationship is a medical issue that can only be proven by probative medical opinion evidence, lay opinions are not relevant.[17]

The Board has held that the mere fact that a condition manifests itself during a period of employment does not raise an inference of causal relation.[18] An award of compensation may not be based on surmise, conjecture, speculation, or upon appellant's own belief that there was a causal relationship between her condition and her employment.[19] Causal relationship must be based on rationalized medical opinion evidence.[20] A physician must accurately describe appellant's work duties and medically explain the pathophysiological process by which these duties would have caused or aggravated his condition.[21] As appellant has failed to submit a rationalized medical opinion supporting that her medical condition was causally related to the

[14] *Id*.

[15] *J.S.*, Docket No. 14-0818 (issued August 7, 2014).

[16] *Ricky S. Storms*, 52 ECAB 349 (2001) (while the opinion of a physician supporting causal relationship need not be one of absolute medical certainty, the opinion must not be speculative or equivocal. The opinion should be expressed in terms of a reasonable degree of medical certainty).

[17] *P.K.*, Docket No. 10-0434 (issued August 20, 2010).

[18] *L.D.*, Docket No. 09-1503 (issued April 15, 2010); *D.I.*, 59 ECAB 158 (2007); *Daniel O. Vasquez*, 57 ECAB 559 (2006).

[19] *Patricia J. Glenn*, 53 ECAB 159, 160 (2001).

[20] *M.E.*, Docket No. 14-1064 (issued September 29, 2014).

[21] *Solomon Polen*, 51 ECAB 341 (2000) (rationalized medical evidence must relate specific employment factors identified by the claimant to the claimant's condition, with stated reasons by a physician). *See also G.G.*, Docket No 15-0234 (issued April 9, 2015).

accepted employment incident, she did not meet her burden of proof to establish an employment-related traumatic injury.

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 her burden of proof to establish a right arm injury causally related to the accepted June 12, 2013 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 29, 2016 is affirmed.

Issued: January 18, 2017
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

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