

repetitive pulling, and turning. Appellant first became aware of her condition(s) on March 1, 2013, but it was not until May 1, 2015 that she first realized her disease or illness was caused or aggravated by factors of her federal employment. She did not stop work.

In an October 3, 2016 letter, OWCP advised appellant of the deficiencies of her claim and afforded her 30 days to submit additional evidence and respond to its inquiries.

In response, appellant submitted a narrative statement indicating that her federal duties included casing mail, which required use of her arms to place mail in respective slots, reaching up, leveling, and reaching down. She was also required to stand and twist her upper body and/or step to face the case. Appellant would then pull down mail and place it in trays, which required her to use her arms and back, with her left arm holding the weight. She moved full trays of mail from the desk to the cart and into a vehicle, sometimes as many as five long trays. Appellant also pushed a large cart loaded with mail and parcels from her workstation to her vehicle, which required use of her back, arms, legs, and entire body. Once in the vehicle, she would have to pull mail from the left and deliver it into mailboxes on the right, which required twisting and/or bending her upper body, turning her head from left to center to right, and also looking around for traffic when she needed to pull away from the mailboxes. When she had a large parcel, appellant was required to exit the vehicle, walk to the front door, and place it on the ground, which required lifting, walking, and bending over.

On January 24, 2012 Jeannie Mueller, a physician assistant, indicated that appellant was a right-handed rural carrier who developed some numbness particularly along the ulnar aspect of her left hand for the past several months and had a prior history of bilateral carpal tunnel surgeries performed in early 2000. She also noted that nerve conduction studies suggested a probable ulnar neuropathy, left side greater than right.

Reports dated December 15, 2011, February 28, 2012, September 25, 2014, and March 26, 2015 from Dr. Wenshu Yu, a Board-certified rheumatologist, diagnosed generalized arthralgia due to degenerative osteoarthritis and mild peripheral neuropathy of the hand, as well as osteopenia. Dr. Yu noted a family history of hemochromatosis, which was often associated with early onset osteoarthritis, but appellant's screening for hemochromatosis was negative. Dr. Yu reported that appellant had increasing hand and feet pain "most likely" due to generalized inflammatory osteoarthritis and opined that they need to rule out other connective tissue diseases.

On March 2, 2012 Dr. Robert H. Fox, a Board-certified neurosurgeon, diagnosed probable ulnar neuropathy with compression at the cubital tunnel region, history of bilateral carpal tunnel syndrome, and history of osteoarthritis. He noted that appellant worked as a rural carrier and had a sister who died from a neurosarcoma affecting the sciatic nerve. Dr. Fox recommended surgical intervention. In a July 18, 2012 progress report, he indicated that he had performed a left-sided ulnar nerve release and diagnosed status post left cubital tunnel release with improved symptoms.

A diagnostic bone density study dated February 3, 2015 revealed osteopenia in the left hip and neck.

X-rays of the neck dated February 25, 2015 demonstrated marked degenerative change throughout the cervical spine with reversal of the normal cervical lordosis and mild anterior subluxation of C2 on C3, mildly progressed in severity as compared to a prior study.

In reports dated March 20 and July 15, 2015, Dr. John R. Marlin, a Board-certified family practitioner, diagnosed cervicgia with right upper extremity radiculopathy down the lateral side of the left arm secondary to cervical spondylosis, right shoulder pain (supraspinatus impingement vs. radiculopathy or arthritis), chronic right foot pain due to swelling and bony deformity (arthritis vs. bone spur), and left knee pain secondary to patellofemoral degenerative disease with anserine bursitis. He indicated that appellant's left knee pain began while on vacation six weeks prior to her July 15, 2015 appointment and a June 23, 2015 x-ray showed degenerative disease of the patella-femoral joint with effusion. Appellant requested a work excuse note because she felt that lifting and getting in and out of vehicles would aggravate her symptoms. Dr. Marlin referred appellant to physical therapy and appellant submitted physical therapy notes dated April 22, 2015.

In a December 28, 2015 report, Dr. Brian P. Witwer, a Board-certified neurosurgeon, diagnosed diffuse degenerative changes of the cervical spine, worst at C7-T1 with significant lateral recess narrowing and central canal stenosis and spondylolisthesis. He recommended surgical intervention to prevent progression of myelopathic symptoms given appellant's symptoms/signs consistent with cervical myelopathy, including clumsiness of upper extremities and gait instability. Dr. Witwer noted that appellant's neck and bilateral arm pain began several years prior and had worsened with time. Appellant's pain was aggravated by bending and reaching down.

On January 15, 2016 Dr. Marlin continued to diagnose chronic pain secondary to osteoarthritis, as well as depression and hypertension.

In a February 12, 2016 report, Dr. Logan M. McDanel, a Board-certified neurologist, indicated that for the past several years appellant had fairly severe chronic aching neck pain and some radiation of pain bilaterally in the arms. The most prominent pain was on the right, but occurred in the left as well, and radiated through the triceps along the lateral portion of the forearm and into the 4th and 5th digits. Heavy use of the arm made it worse and extending her neck sometimes made it better. Dr. McDanel found that appellant's gait was normal with appropriate arm swing. He diagnosed osteoarthritis of the cervical spine with myelopathy and indicated that appellant did appear to have a right C8 radiculopathy. Dr. McDanel opined that although he did not clearly identify a radiculopathy on the left side, he suspected that she had one there as well due to her symptoms and history of prior carpal tunnel and ulnar nerve transpositions surgeries on the left arm.

An electromyography (EMG) and nerve conduction velocity (NCV) studies dated February 12, 2016 demonstrated ulnar nerve entrapment at the right elbow, carpal tunnel subacute likely C8 radiculopathy on the right, and some residual ulnar neuropathy on the left. There was no evidence of median nerve pathology or radiculopathy.

In reports dated March 21, September 15, and October 6, 2016, Dr. Witwer diagnosed right-sided C8 radiculopathy with myelopathy, severe cervical spondylosis with C7-T1

anterolisthesis, and cervical stenosis. He noted that appellant's symptoms had progressed since he last saw her six months prior when she was having worsening clumsiness in her hands, paresthesias, and gait instability. Dr. Witwer continued to recommend surgical intervention.

By decision dated December 9, 2016, OWCP denied the claim because the evidence of record failed to establish a causal relationship between appellant's conditions and factors of her federal employment.

Subsequently, the employing establishment submitted a position description and a statement indicating that appellant's federal duties required constant twisting, turning, bending, lifting, pulling, and pushing while driving, delivering mail, and lifting parcels up to 70 pounds.

On January 17, 2017 appellant requested reconsideration and submitted a January 5, 2017 report from an unidentifiable healthcare provider of St. Mary's Neurosurgery Center for Brain and Spine Surgery indicating that appellant underwent cervical spine fusion surgery on October 19, 2016 performed by Dr. Witwer and may require additional surgery at the C2-3 level and/or additional levels in the future. It noted that appellant was suffering from osteopenia, osteoarthritis, diffuse degenerative changes, and radiculopathy of her cervical spine shown on her diagnostic studies. The healthcare provider indicated that appellant's conditions would increasingly continue to deteriorate overtime due to the degeneration of cells, with activities of daily living, work, exercise, eating habits, etc.

By decision dated February 24, 2017, OWCP denied modification of its prior decision.

LEGAL PRECEDENT

A claimant seeking benefits under FECA 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, 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.²

To establish that an injury was sustained in the performance of duty in an occupational disease claim, an employee must submit 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.³

Certain healthcare providers such as physician assistants, nurse practitioners, physical therapists, and social workers are not considered "physician[s]" as defined under FECA.⁴

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

³ *See D.R.*, Docket No. 09-1723 (issued May 20, 2010). *See also Roy L. Humphrey*, 57 ECAB 238, 241 (2005); *Ruby I. Fish*, 46 ECAB 276, 279 (1994); *Victor J. Woodhams*, 41 ECAB 345 (1989).

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

Consequently, their medical findings and/or opinions will not suffice for purposes of establishing entitlement to FECA benefits.⁵

ANALYSIS

The Board finds that appellant failed to meet her burden of proof to establish that factors of her federal employment caused or aggravated her diagnosed medical conditions. Appellant identified the factors of employment that she believed caused her conditions, including constant twisting, turning, bending, lifting, pulling, and pushing while driving, delivering mail, and lifting parcels up to 70 pounds at work, which OWCP accepted as factual. However, in order to establish a claim for an employment-related injury, she must also submit rationalized medical evidence which explains how or why her medical conditions were caused or aggravated by the implicated employment factors.⁶

The February 3, 2015 bone density study confirmed the diagnosis of osteopenia; however, the diagnostic study does not address the etiology of appellant's left hip and neck conditions. Moreover, the February 25, 2015 x-rays of the neck confirmed the diagnoses of degenerative changes and mild anterior subluxation of C2 on C3, but the diagnostic studies also do not address the etiology of appellant's cervical condition. Similarly, the EMG and NCV studies dated February 12, 2016 demonstrated ulnar nerve entrapment at the right elbow, carpal tunnel subacute likely C8 radiculopathy on the right, and some residual ulnar neuropathy on the left; however, these diagnostic studies also fail to address the etiology of appellant's bilateral hand and arm conditions. As the January 5, 2017 report is from an unidentifiable healthcare provider, it cannot be determined whether this evidence is from a physician as defined in 5 U.S.C. § 8101(2), it does not constitute competent medical evidence.⁷ Consequently, the above-noted evidence is insufficient to satisfy appellant's burden of proof with respect to causal relationship.⁸

Appellant further submitted evidence from physician assistants and physical therapists. These documents do not constitute competent medical evidence because neither a physician

⁵ *K.W.*, 59 ECAB 271, 279 (2007); *David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006). A report from a physician assistant or certified nurse practitioner will be considered medical evidence if countersigned by a qualified physician. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3a(1) (January 2013).

⁶ *See A.C.*, Docket No. 08-1453 (issued November 18, 2008).

⁷ *R.M.*, 59 ECAB 690, 693 (2008). *See C.B.*, Docket No. 09-2027 (issued May 12, 2010) (a medical report may not be considered as probative medical evidence if there is no indication that the person completing the report qualifies as a physician as defined in 5 U.S.C. § 8101(2) and reports lacking proper identification do not constitute probative medical evidence).

⁸ *See supra* notes 2 to 5.

assistant nor a physical therapist is considered a “physician” as defined under FECA.⁹ As such, this evidence is also insufficient to meet appellant’s burden of proof.

In his reports, Dr. Marlin diagnosed cervicalgia with right upper extremity radiculopathy down the lateral side of the left arm secondary to cervical spondylosis, right shoulder pain, chronic right foot pain due to swelling and bony deformity, and left knee pain secondary to patellofemoral degenerative disease with anserine bursitis. He indicated that appellant’s left knee pain began while on vacation six weeks prior to her July 15, 2015 appointment and a June 23, 2015 x-ray showed degenerative disease of the patella-femoral joint with effusion. Appellant requested a work excuse note because she felt that lifting and getting in and out of vehicles would aggravate her symptoms. Dr. Marlin attributed appellant’s left knee condition to a nonwork-related incident. Further, he did not provide any medical rationale explaining how or why appellant’s constant twisting, turning, bending, lifting, pulling, and pushing at work caused or aggravated her other conditions. Thus, the Board finds that the reports from Dr. Marlin are insufficient to establish that appellant sustained an employment-related injury.

In a December 28, 2015 report, Dr. Witwer diagnosed diffuse degenerative changes of the cervical spine, worst at C7-T1 with significant lateral recess narrowing and central canal stenosis and spondylolisthesis. He noted that appellant’s neck and bilateral arm pain began several years prior and had worsened with time. In his 2016 reports, Dr. Witwer diagnosed right-sided C8 radiculopathy with myelopathy, severe cervical spondylosis with C7-T1 anterolisthesis, and cervical stenosis and recommended a course of surgical intervention. He noted that appellant’s conditions were aggravated by bending and reaching down, but such generalized statements do not establish causal relationship.¹⁰ Dr. Witwer did not provide sufficient medical rationale explaining how or why appellant’s new or preexisting neck and bilateral arm conditions were caused or aggravated by constant twisting, turning, bending, lifting, pulling, and pushing at work. The need for rationale is particularly important as the record indicates that appellant had a prior history of bilateral carpal tunnel surgeries performed in early 2000 and a left-sided ulnar nerve release surgery performed by Dr. Fox in 2012. Therefore, the Board finds that the reports from Dr. Witwer are insufficient to establish neck and bilateral arm conditions causally related to factors of appellant’s federal employment.

Reports from Drs. Yu, Fox, and McDaneld merely provided medical diagnoses, without offering any opinions regarding the cause of the 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.¹¹ Consequently, this evidence is also insufficient to satisfy appellant’s burden of proof with respect to causal relationship.¹²

⁹ 5 U.S.C. § 8101(2); *Sean O’Connell*, 56 ECAB 195 (2004) (physician assistants); *Jennifer L. Sharp*, 48 ECAB 209 (1996) (physical therapists). See also *Gloria J. McPherson*, 51 ECAB 441 (2000); *Charley V.B. Harley*, 2 ECAB 208, 211 (1949) (a medical issue such as causal relationship can only be resolved through the submission of probative medical evidence from a physician).

¹⁰ See *K.W.*, Docket No. 10-98 (issued September 10, 2010).

¹¹ See *C.B.*, *supra* note 7; *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

¹² See *supra* notes 2 to 5.

As appellant has not submitted any rationalized medical evidence to support her allegation that she sustained an injury causally related to the accepted employment factors, she failed to meet her burden of proof to establish a 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 her burden of proof to establish a medical condition causally related to factors of her federal employment.

ORDER

IT IS HEREBY ORDERED THAT the February 24, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 26, 2017
Washington, DC

Christopher J. Godfrey, 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