United States Department of Labor
Employees' Compensation Appeals Board

E.R., Appellant	)	
	)	
and	)	**Docket No. 16-1634**
	)	**Issued: May 25, 2017**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS HEALTH ADMINISTRATION, North Little Rock, AR, Employer	)	

Appearances:
James W. Stanley, 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 August 15, 2016 appellant, through counsel, filed a timely appeal from a July 25, 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 that her cervical and right shoulder conditions causally related to the accepted May 15, 2015 employment incident.

FACTUAL HISTORY

On May 19, 2015 appellant, then a 59-year-old nurse, filed a traumatic injury claim (Form CA-1) alleging that on May 15, 2015 she sustained an upper back and right shoulder injury when transferring and repositioning a patient from a hoya lift to a wheelchair. She notified her supervisor and stopped work on the date of injury.

The employing establishment issued appellant a properly completed Form CA-16, authorization for medical treatment and examination, dated May 20, 2015, which indicated that she was authorized to seek medical treatment for her upper back and right shoulder injury due to the May 15, 2015 employment incident.

In medical reports dated May 20 through June 10, 2015, Dr. Joel Smith, a Board-certified orthopedic surgeon, reported that appellant complained of right shoulder and neck pain after injuring herself at work on May 15, 2015 when she was trying to lift and transfer a patient. He noted that a May 20, 2015 x-ray of the right shoulder revealed degenerative acromioclavicular joint disease and an x-ray of the cervical spine revealed degenerative disc disease and facet arthrosis. Dr. Smith diagnosed right shoulder pain, neck pain, cervicalgia, and cervical radiculopathy brachial neuritis or radiculitis. He provided work restrictions and recommended physical therapy and a magnetic resonance imaging (MRI) scan due to complaints of continued pain. In an attending physician's report (Form CA-20) received on June 2, 2015, Dr. Smith reported that on May 15, 2015 appellant was lifting a patient for transfer when the patient slid. He diagnosed cervicalgia and checked the box marked "yes" to indicate that the condition was caused or aggravated by the employment incident.

In support of her claim, appellant submitted physical therapy notes dated June 2 through 24, 2015 documenting treatment for her neck and shoulder pain.

In a June 15, 2015 diagnostic report, Dr. Lephiew Dennington, a Board-certified radiologist, reported that an MRI scan of the cervical spine revealed osteoarthrosis and disc degeneration with foraminal narrowing through the cervical spine, more notably on the right than left.

In another June 15, 2015 diagnostic report, Dr. Dennington reported that an MRI scan of the right shoulder revealed small subdeltoid fluid collection which could be bursitis; mild infraspinatus strain verses changes from impingement near the myotendinous junction without muscular tear or atrophy; and suspected focal posterior superior labral tear.

By letter dated July 8, 2015, OWCP informed appellant that the evidence of record was insufficient to support her claim. Appellant was advised of the medical and factual evidence necessary to establish her claim and was afforded 30 days to submit this evidence.

In support of her claim, appellant submitted physical therapy notes dated June 14 through August 3, 2015 documenting treatment for her neck and shoulder pain.

In a June 30, 2015 medical report, Dr. Smith reported that appellant complained of difficulty walking as well as pain in the neck and thoracic spine. He diagnosed cervical spine pain.

In an August 12, 2015 medical report, Dr. Stephen Paulus, Board-certified in physical medicine and rehabilitation, reported that appellant presented with complaints of continued neck pain. He noted that her June 15, 2015 MRI scan of the cervical spine revealed multiple ulcers of degenerative changes in the intervertebral discs with multilevel uncovertebral joint hypertrophy. Dr. Paulus further reported mild degenerative retrolisthesis of C5 on C6 which, in the context of broad-based disc bulge, resulted in moderate central canal stenosis and abutment of the descending cord. He explained that the above-noted degenerative changes resulted in right worse than left neuroforaminal encroachment at C3-C4, C4-C5, C5-C6, and C6-C7. Dr. Paulus noted comparison with a January 29, 2015 MRI scan of the cervical spine stating that he did not see much evidence of acute pathology or significant worsening of the above noted degenerative changes in the interim. With respect to the May 15, 2015 employment incident, he explained that there were no objective radiologic markers for pain exacerbation, though symptom development could be possible with injuries in the absence of objective radiologic changes. Dr. Paulus further diagnosed cervical radiculitis, spinal stenosis in the cervical region, degeneration of cervical intervertebral disc, and acquired spondylolisthesis. He concluded that he did not see much objective radiologic change between the January and June 2015 cervical spine MRI scans, although it was possible to develop symptoms from prior degenerative changes. Dr. Paulus recommended epidural steroid injections.

In a June 26, 2016 urgent care report, Dr. James Rice, an emergency medicine physician, reported that appellant was treated for light headedness, dizziness, and weakness in the lower extremities. He noted that a computerized tomography (CT) scan of the head and chest x-ray revealed normal findings.

By decision dated August 21, 2015, OWCP denied appellant's claim, finding that the evidence of record failed to establish that her diagnosed conditions were causally related to the accepted May 15, 2015 employment incident.

On September 16, 2015 appellant, through counsel, requested an oral hearing before an OWCP hearing representative.

In medical reports dated December 7, 2015 through March 15, 2016, Dr. Ann Layton, Board-certified in internal medicine, reported that appellant complained of chronic neck and right shoulder pain. She diagnosed degenerative joint disease and right rotator cuff syndrome. Dr. Layton recommended a repeat MRI scan of the cervical spine and right shoulder which was performed on February 15, 2016 by Dr. John Baden, a Board-certified diagnostic radiologist. Dr. Baden reported that the February 15, 2016 MRI scan of the right shoulder revealed normal rotator cuff and query tiny focal tear at the superior labrum. He further reported that the MRI scan of the cervical spine revealed C5-C6 spondylosis with central disc extrusion resulting in moderate-to-severe canal stenosis and mild mass effect on the spinal cord; C3-C4 spondylosis

with mild-to-moderate resulting canal stenosis and moderate bilateral foraminal stenosis; and C4-C5 and C6-C7 spondylosis with mild resulting canal stenosis. In a February 22, 2016 medical report, Dr. Layton reported that the MRI scan of the cervical spine showed bulging effect of disc with moderate-to-severe spinal canal stenosis while the repeat MRI scan of the right shoulder revealed a small labral tear.

In medical reports dated December 23, 2015 through January 28, 2016, Dr. Julio Olaya, a Board-certified anesthesiologist, reported that appellant presented for injections due to neck and back pain from a work-related injury. He diagnosed cervical radiculopathy, cervical spondylosis, cervical spinal stenosis, and myofascial pain syndrome.

In a March 4, 2016 report, Jessica Moore, an occupational therapist, performed a functional capacity evaluation (FCE).

In a March 10, 2016 medical report, Dr. Amir Qureshi, Board-certified in physical medicine and rehabilitation, diagnosed cervicalgia due to significant right shoulder and neck pain. He further noted diagnoses of right shoulder pain, cervical spondylosis, cervical spinal stenosis, cervical radiculopathy, lumbar radiculopathy, lumbar spondylosis, and myofascial pain.

In a March 24, 2016 medical report, Dr. Ali Raja, Board-certified in neurological surgery, reported that he evaluated appellant for neck pain radiating to the right shoulder and upper back. Appellant noted no complaints of pain until a work injury on May 15, 2015. Treatment included physical therapy and trigger point injections. Dr. Raja diagnosed neck pain, cervical spondylosis, cervical spinal stenosis, foraminal stenosis of cervical region, and bilateral numbness and tingling of arms and legs. He noted review of the February 15, 2016 MRI scan of the cervical spine which revealed evidence of C5-C6 spondylosis with central disc extrusion; moderate-to-severe canal stenosis and mass effect on the spinal cord along C3-C4 spondylosis; mild-to-moderate canal stenosis; bilateral moderate foraminal stenosis; and mild degenerative changes at C4-C5 and C6-C7. Dr. Raja discussed treatment options with appellant including surgery.

In an April 25, 2016 medical report, Dr. Smith reported that he initially treated appellant for shoulder and neck pain. He explained that appellant was diagnosed with pain at the time of the initial visit because it was impossible to diagnose with medical certainty whether she had foraminal stenosis and nerve impingement without advanced imaging testing. Dr. Smith reported that an MRI scan was eventually obtained which demonstrated the findings of facet arthrosis, foraminal stenosis, and nerve impingement. He explained that appellant did not have any of these symptoms prior to her work incident, which clearly established the causal relationship between the incident and current diagnoses.

A hearing was held on May 18, 2016 at which appellant testified in support of her claim. She reported that she had no prior cervical injury until the May 15, 2015 employment incident and had been unable to work due to the severity of her condition. Appellant reported that she worked light duty until February 22, 2016 and underwent surgery on April 15, 2016. She was advised of the medical evidence needed in support of her claim and the record was held open for 30 days.

By letter dated May 18, 2016, counsel for appellant provided duty status reports (Form CA-17) and work restrictions from her treating physicians dated August 12, 2015 through May 11, 2016. In a May 11, 2016 report, Dr. Raja reported that appellant was under his care following a recent cervical surgery and was advised to remain off work beginning April 15, 2016.

By letter dated May 31, 2015, counsel for appellant argued that the medical evidence submitted established a work-related injury as she had no prior medical disorder and her symptoms arose after the work-related incident.

By decision dated July 25, 2016, OWCP's hearing representative affirmed the August 21, 2015 decision finding that the evidence of record failed to establish that appellant's diagnosed conditions were causally related to the accepted May 15, 2015 employment incident.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish 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 filed within the applicable time limitation, that an injury was sustained while in the performance of duty as alleged, and that any disability or specific condition for which compensation is claimed are causally related to the employment injury.[3] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated on a traumatic injury or a occupational disease.[4]

In order to determine whether an employee actually sustained an 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 which must be considered in conjunction with one another. The first component to be established is that the employee actually experienced the employment incident which is alleged to have occurred.[5] The second component is whether the employment incident caused a personal injury and generally can be established only by medical evidence.

To establish causal relationship between the condition, as well as any attendant disability claimed and the employment event or incident, the employee must submit rationalized medical opinion evidence supporting such a causal relationship.[6] The opinion of the physician must be based on a complete factual and medical background of the claimant, 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 claimant. This medical opinion must include an accurate history of the employee's employment injury and must explain how the condition is related to the injury. The weight of

[3] *Gary J. Watling*, 52 ECAB 278 (2001); *Elaine Pendleton*, 40 ECAB 1143, 1154 (1989).

[4] *Michael E. Smith*, 50 ECAB 313 (1999).

[5] *Elaine Pendleton*, *supra* note 3.

[6] *See* 20 C.F.R. § 10.110(a); *John M. Tornello*, 35 ECAB 234 (1983).

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.[7]

ANALYSIS

OWCP accepted that the May 15, 2015 employment incident occurred as alleged. The issue is whether appellant established that the employment incident caused her diagnosed cervical and right shoulder conditions. The Board finds that she has not submitted sufficient medical evidence to establish that her cervical and right shoulder conditions were causally related to the May 15, 2015 employment incident.[8]

In support of her claim, appellant submitted medical reports dated May 20 through June 20, 2015 from Dr. Smith, her attending physician. Dr. Smith described the May 15, 2015 employment incident and diagnosed right shoulder pain, neck pain, cervicalgia, and cervical radiculopathy brachial neuritis or radiculitis. On a Form CA-20, he checked the box marked "yes" when asked if the condition was caused or aggravated by the employment incident. The Board has held that a report that addresses causal relationship with a checkmark, without medical rationale explaining how the work condition caused the alleged injury, is of diminished probative value and insufficient to establish causal relationship.[9]

In a subsequent April 25, 2016 report, Dr. Smith reported that appellant was initially diagnosed with pain, but a subsequent MRI scan confirmed findings of facet arthrosis, foraminal stenosis, and nerve impingement. He explained that appellant did not have any of these symptoms prior to her work injury, which clearly established causal relationship between the incident and current diagnoses. The Board notes that appellant's diagnostic studies revealed degenerative conditions related to the right shoulder and cervical spine. Dr. Smith's statement on causation fails to provide a sufficient explanation as to the mechanism of injury and did not adequately explain how the May 15, 2015 employment incident would cause or aggravate her preexisting conditions other than generally noting the development of pain. Moreover, he failed to discuss how these preexisting conditions had progressed beyond what might be expected from the natural progression of that condition.[10] A well-rationalized opinion is particularly warranted in this case due to appellant's history of preexisting conditions.[11] The Board has held that an opinion that a condition is causally related because the employee was asymptomatic before the injury is insufficient, without adequate rationale, to establish causal relationship.[12]

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

[8] *See Robert Broome*, 55 ECAB 339 (2004).

[9] *See Calvin E. King, Jr*., 51 ECAB 394 (2000); *see also Frederick E. Howard, Jr*., 41 ECAB 843 (1990).

[10] *R.E.*, Docket No. 14-868 (issued September 24, 2014).

[11] *K.P.*, Docket No. 14-1330 (issued October 17, 2014).

[12] *T.M.*, Docket No. 08-975 (issued February 6, 2009); *Michael S. Mina*, 57 ECAB 379 (2006).

In an August 12, 2015 medical report, Dr. Paulus diagnosed neck pain, cervical radiculitis, spinal stenosis in cervical region, degeneration of cervical intervertebral disc, and acquired spondylolisthesis. The Board notes that the report of Dr. Paulus fails to provide support for a work-related cervical injury. Dr. Paulus provided findings comparing a January 29 and June 15, 2015 MRI scan of the cervical spine. His report suggests that appellant's cervical injuries were a result of a preexisting degenerative condition, noting degenerative findings on both studies without much evidence of acute pathology or significant worsening of the noted degenerative changes. With respect to the May 15, 2015 work injury, Dr. Paulus reported that he did not see much objective radiologic change between the January and June 2015 MRI scan as there was no marker for pain exacerbation. He failed to provide a firm conclusion that the employment incident did in fact cause or aggravate appellant's diagnosed conditions.[13] 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.[14] A medical opinion should reflect a correct history and offer a medically sound explanation by the physician of how the specific employment incident physiologically caused or aggravated the diagnosed conditions.[15] As such, Dr. Paulus report fails to establish a work-related cervical condition.[16]

Dr. Layton's medical reports dated December 7, 2015 through March 15, 2016 are also insufficient to establish appellant's claim. While she provided diagnoses of degenerative joint disease, rotator cuff syndrome right shoulder, small labral right shoulder tear, and cervical bulging disc with spinal canal stenosis, Dr. Layton failed to proffer any opinion regarding the cause of appellant's injuries, nor did she provide a history of the May 15, 2015 employment incident which could be related to the diagnoses provided. The Board has found that a physician must provide a narrative description of the identified employment incident and a reasoned opinion on whether the employment incident described caused or contributed to the diagnosed medical condition.[17] As such, Dr. Layton's reports are of limited probative value and insufficient to meet appellant's burden of proof.[18]

In a March 24 and May 11, 2016 medical report, Dr. Raja diagnosed neck pain, cervical spondylosis, cervical spinal stenosis, and foraminal stenosis of cervical region yet failed to state any opinion on the cause of appellant's injuries. While he noted no complaints of pain prior to the May 15, 2015 employment incident, an opinion that a condition is causally related because the employee was asymptomatic before the injury is insufficient to establish appellant's claim.[19] The Board has held that medical evidence that does not offer any opinion regarding the cause of

[13] *See Michael R. Shaffer*, 55 ECAB 339 (2004).

[14] *Rickey S. Storms*, 52 ECAB 349 (2001). *See also Beverly R. Jones*, 55 ECAB 411 (2004).

[15] *T.G.*, Docket No. 14-751 (issued October 20, 2014).

[16] *Supra* note 12.

[17] *John W. Montoya*, 54 ECAB 306 (2003).

[18] *See L.M.*, Docket No. 14-973 (issued August 25, 2014); *R.G.*, Docket No. 14-113 (issued April 25, 2014); *K.M.*, Docket No. 13-1459 (issued December 5, 2013); *A.J.*, Docket No. 12-548 (issued November 16, 2012).

[19] *Supra* note 12.

an employee's condition is of limited probative value on the issue of causal relationship.[20] Thus, Dr. Raja's report is of limited probative value and insufficient to meet appellant's burden of proof.[21]

The remaining medical evidence of record is also insufficient to establish causal relationship between appellant's cervical and right shoulder injuries and the May 15, 2015 employment incident. The reports of Dr. Dennington and Dr. Baden are of no probative value as they interpreted diagnostic imaging studies with no opinion on the cause of appellant's injury.[22] While the reports of Dr. Olaya and Dr. Qureshi document injections and treatment for the cervical spine and right shoulder, they are of no probative value as they fail to discuss the May 15, 2015 employment incident.[23]

The reports submitted from physical and occupational therapists are also insufficient to establish appellant's claim. Registered nurses, physical and occupational therapists, and physician assistants are not considered physicians as defined under FECA. Thus their opinions are of no probative value.[24]

The Board notes that there is no requirement that the federal employment be the only cause of appellant's injury. An employee is not required to prove that occupational factors are the sole cause of her claimed condition. If work-related exposures caused, aggravated or accelerated appellant's condition, she is entitled to compensation.[25] However, an award of compensation may not be based on surmise, conjecture, speculation, or on the employee's own belief of causal relation.[26] Appellant's honest belief that the May 15, 2015 employment incident caused her medical injury is not in question, but that belief, however sincerely held, does not constitute the medical evidence necessary to establish causal relationship.[27]

[20] *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *S.E.*, Docket No. 08-2214 (issued May 6, 2009).

[21] *Id.*

[22] *Supra* note 20.

[23] *Id.*

[24] 5 U.S.C. § 8102(2) of FECA provides as follows: (2) 'physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law. *See also Roy L. Humphrey*, 57 ECAB 238 (2005). The physical therapy reports and reports from an occupational therapist are also insufficient to establish appellant's claim. Physical therapists and occupational therapists are not a physician and a physical therapist or occupational therapist's opinion regarding diagnosis or causal relationship is of no probative value. *V.C.*, Docket No. 14-1124 (issued November 3, 2014).

[25] *See Beth P. Chaput*, 37 ECAB 158, 161 (1985); *S.S.*, Docket No. 08-2386 (issued June 5, 2008).

[26] *D.D.*, 57 ECAB 734 (2006).

[27] *E.W.*, Docket No. 16-1729 (issued May 12, 2017).

In the instant case, the record lacks rationalized medical evidence establishing a causal relationship between the May 15, 2015 employment incident and appellant's diagnosed cervical and right shoulder conditions. Thus, appellant has failed to meet her burden of proof.[28]

Appellant may submit additional evidence, together with a written request for reconsideration, to OWCP within one year of the Board's merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.606 and 10.607.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that her cervical and right shoulder conditions are causally related to the accepted May 15, 2015 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the Office of Workers' Compensation Programs' decision dated July 25, 2016 is affirmed.

Issued: May 25, 2017
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

[28] When the employing establishment properly executes a Form CA-16 which authorizes medical treatment as a result of an employee's claim for an employment-related injury, the Form CA-16 creates a contractual obligation, which does not involve the employee directly, to pay for the cost of the examination or treatment regardless of the action taken on the claim. The period for which treatment is authorized by a Form CA-16 is limited to 60 days from the date of issuance, unless terminated earlier by OWCP. *See* 20 C.F.R. § 10.300(c); *Tracy P. Spillane*, 54 ECAB 608, 610 (2003).