United States Department of Labor
Employees' Compensation Appeals Board

R.S., Appellant	)	
and	)	**Docket No. 17-1139**
	)	**Issued: November 16, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Jersey City, NJ, 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 May 2, 2017 appellant, through counsel, filed a timely appeal from a February 9, 2017 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.

ISSUE

The issue is whether appellant met his burden of proof to establish a traumatic injury causally related to the accepted February 3, 2015 employment incident.

[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.*

FACTUAL HISTORY

On May 1, 2015 appellant, then a 57-year-old tractor trailer operator, filed a traumatic injury claim (Form CA-1) alleging that on February 3, 2015 he slipped on ice and fell backwards while he was walking out from the rear of a trailer. He noted that when he attempted to get up, he fell on his knees. Appellant listed the nature of his injury as soreness to his back and both knees. He did not stop work.

Appellant was treated by multiple chiropractors at the Jersey City Rehabilitation Clinic from February 23 through April 3, 2015, including Dr. John Bortolussi, Dr. Louis Stimmel, Dr. James Prette, and Dr. Charles Collins. These chiropractors treated appellant for neck pain and stiffness in both shoulders, upper and lower back pain, pain radiating into both legs, and pain in both knees. Appellant was treated with traction, moist heat cryotherapy, and vibratory massage therapy.

On March 31, 2015 appellant underwent a magnetic resonance imaging (MRI) scan of the right knee that was interpreted by Dr. Alkies Lapas, a diagnostic neuroradiologist and osteopath, as showing horizontal cleavage tear at the posterior horn of the medial meniscus, and osteochondral erosions at the posterior aspect of the medial femoral condyle and at the medial femoral trachlear surface.

OWCP also received physical therapy notes from the Jersey City Rehabilitation Clinic dated April 8, 2015.

By letter dated June 25, 2015, OWCP informed appellant that further factual and medical evidence was necessary to support his claim, and afforded him 30 days to submit the requested information. Appellant did not respond within the allotted time.

In a decision dated August 7, 2015, OWCP denied appellant's claim. It found that, although appellant had established that an incident occurred as alleged, he failed to submit medical evidence containing a medical diagnosis in connection with the incident.

On September 1, 2015 appellant requested a telephonic hearing before an OWCP hearing representative. OWCP received additional medical evidence on January 7, 2016.

Appellant was treated at the emergency department of Christ Hospital on February 4, 2015. He reported that, while at work the day before, he slipped and fell onto the ice, landing on his upper back. Appellant noted that he then jumped up quickly and fell forward, landing on his knees. He complained of pain in his upper back, neck and bilateral knee pain. Dr. Tania A. Afonso, an osteopath and emergency medicine physician, diagnosed sprain of the knee and whiplash injury to the neck. On the same date Dr. Supreet Singh, a Board-certified radiologist, interpreted an x-ray of appellant's cervical spine as evincing no fracture or joint dislocation.

On November 17, 2015 weight bearing x-rays were taken of both knees and Dr. Nina L. Brogle, a Board-certified radiologist, found moderate osteoarthrosis, right greater than left, and enthesopathy. She found no acute fracture or dislocation.

An MRI scan of the right knee taken on December 11, 2015 was interpreted by Dr. Stacey Siegel, a Board-certified radiologist, as showing tear posterior horn and body medial meniscus with irregularity along the inferior articular surface; interstitial tear anterior cruciate ligament; abnormal signal low on T1 with increased signal on the T2 weighted images at the anterior and lateral aspect of the medial femoral condyle which may represent a cyst or chondral lesion; bone marrow edema anterior aspect of the medial femoral condyle; and osteoarthritis medial to lesser extent lateral tibiofemoral joint space, and small joint effusion.

At the hearing held on April 13, 2016, appellant testified that he had been a tractor/trailer driver for 10 years, that on February 3, 2015 he had a slip and fall at work and landed on ice, and that in the process of trying to get up he fell onto his knees. He noted that he finished his shift on the day he fell, but went to the hospital the next day. Appellant testified that he was still having trouble with his back and both of his knees. He noted that in November 2014, prior to his employment injury, he had surgery to fix a tear in his right medial meniscus. Appellant indicated that the problem recurred after the fall.

By decision dated May 18, 2016, the hearing representative affirmed the August 7, 2015 decision. He noted that the file was devoid of medical evidence in which a physician provided an accurate history of injury and an unequivocal medical opinion addressing causal relationship between the accepted employment incident and a definitive diagnosis supported by medical rationale.

On December 28, 2016 appellant, through counsel, requested reconsideration.

Appellant submitted progress notes from the Veterans Administration (VA) Medical Center in East Orange New Jersey dated from December 28, 2006 through November 30, 2016.

In an MRI scan of the right knee taken on June 18, 2014, Dr. Joan K. Kowalec, a Board-certified internist, found a tear of the posterior horn and body medial meniscus with irregularity along the inferior articular surface, interstitial tear anterior cruciate ligament, abnormal signal low on T1 with increased signal on the T2, bone marrow edema anterior aspect of the medial femoral condyle, osteoarthritis medial to lesser extent lateral tibiofemoral joint space, and small joint effusion.

In a March 10, 2015 note, Dr. Alycia N. Antoine, an internist, noted that on February 3, 2015 appellant fell and injured his back and both knees. She stated that appellant was experiencing swelling in his legs at the end of the day.

In a July 27, 2015 note, Dr. Rashima Jain-Ahuja, a Board-certified family practitioner, listed appellant's active problems as tear of the medial meniscus of knee (August 11, 2014), essential hypertension, chronic hepatitis C, osteoarthritis, and open angle glaucoma. She also noted that he had a history of right knee diagnostic arthroscopy and medial meniscus partial meniscectomy on November 15, 2014. Dr. Jain-Ahuja further indicated that appellant had a fall at work on February 3, 2015 at which time he sustained injuries to his back and both knees. With regard to assessment/plan for this chronic right knee pain, she indicated that she encouraged appellant to follow up with workers' compensation and ambulate with a cane.

Appellant underwent an MRI scan of his knees on November 4, 2015 that was interpreted by Dr. Brogle as showing no acute fracture or dislocation in either knee and moderate osteoarthritis, right greater than left.

On July 13, 2016 Dr. Jain-Ahuja noted right knee pain and ankle pain.

Numerous x-rays were taken on October 30, 2016 and were interpreted by Dr. Joey Philip, a radiologist. X-rays of knees showed no significant interval change, mild tricompartmental degenerative changes of the knee, no acute osseous abnormality, and generalized osteopenia of the visual bony structures. X-rays of the left shoulder showed no acute osseous abnormality, mild degenerative osteoarthritic changes suspected in the left acromioclavicular joint, generalized osteopenia of the visualized bony structures, and prominent subacromial osteophytic spurring suspected which may clinically contribute to impingement of the rotator cuff. X-rays of cervical spine showed moderate degenerative spondylitic changes at C5-6 level, generalized osteopenia of the visualized bony structures, no definite acute displaced fracture or subluxation, and straightening of the normal cervical lordotic curvature. X-rays of the lumbar spine showed mild grade 1 retrolisthesis of the L5 with respect to L4, mild multilevel degenerative spondylotic changes in the lumbosacral spine, no acute fracture or subluxation, generalized osteopenia of the visualized bony structures, moderate-to-severe facet degenerative changes suspected in the lower lumbosacral spine bilaterally, and straightening of the normal lumbar lordotic curvature.

In a December 15, 2016 report, Dr. David B. Basch, a Board-certified orthopedic surgeon, noted that appellant slipped and fell on ice on February 3, 2015 and injured his neck and lower back as well as his knees. He noted that appellant continued to experience persistent neck and lower back pain with occasional numbness and tingling throughout his bilateral upper extremities. Dr. Basch noted that appellant was also experiencing a sense of instability in his knees. He diagnosed chronic cervical and lumbar strains (whiplash injury), rule out internal disc disruption and disc herniation; and bilateral knee internal derangement with horizontal cleavage tear of the posterior horn of the medial meniscus with osteochondral lesion to the posterior aspect of the medial femoral condyle and the medial femoral trochlear surface.

By decision dated February 9, 2017, OWCP modified the May 18, 2016 decision. It determined that the evidence now established the factors of employment and that a medical condition had been diagnosed, but that the claim remained denied because the evidence of record did not establish causal relationship between the accepted employment incident and the diagnosed conditions of cervical and lumbar strains and bilateral knee internal derangement with horizontal cleavage tear to the posterior horn of the medial meniscus. Thus, an injury "within the meaning of … (FECA) has not been demonstrated."

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] 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 timely filed within the applicable

[3] *Id*.

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

ANALYSIS

OWCP accepted that the employment incident occurred as alleged and that appellant established a medical diagnosis. However, it denied his claim as the medical evidence failed to establish that the diagnosed medical conditions were causally related to the accepted employment incident.

The Board finds that appellant has failed to submit a rationalized medical opinion establishing causal relationship between the accepted February 3, 2015 incident and any medical diagnosis.

Causal relationship is a medical question that must be established by probative medical opinion from a physician.[10] In support of his claim, appellant submitted multiple notes from chiropractors at the Jersey City Rehabilitation Clinic, including Drs. Bortolussi, Stimmel, Prette,

[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.

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

[10] *C.S.*, Docket No. 17-0399 (issued June 19, 2017).

and Collins. A chiropractor is considered a physician as defined by section 8101(2) of FECA only if his or her services consist of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.[11] No chiropractors of record indicated that x-rays showed a spinal subluxation. Accordingly, these chiropractors are not considered physicians under FECA and their opinions do not constitute competent medical evidence.[12]

OWCP also received a report from appellant's physical therapist. However, reports by a physical therapists have no probative value as a physical therapists are not considered physicians.[13] Therefore, the reports from appellant's physical therapist are insufficient to meet appellant's burden of proof.[14]

Appellant submitted the results of multiple diagnostic studies, including x-rays interpreted by Dr. Brogle, Dr. Singh, and Dr. Philip, and MRI scans interpreted by Dr. Lapas, Dr. Siegel, and Dr. Brogle. These diagnostic studies are of limited probative value as they do not address whether the February 3, 2015 work incident caused any of the diagnosed conditions.[15]

The reports of the remaining physicians also do not establish a medical diagnosis causally related to the February 3, 2015 accepted work injury. Appellant received treatment at the emergency department by Dr. Alfonso on February 4, 2015. Dr. Alfonso described the work incident and diagnosed a sprain of the knees and whiplash injury to appellant's neck. However, the mere fact that a disease or condition manifests itself during a period of employment does not raise an inference of causal relationship between the condition and the employment.[16] A physician must provide a reasoned opinion on whether the employment incident described had caused or contributed to appellant's diagnosed medical conditions.[17] As Dr. Alfonso offered no opinion regarding the cause of appellant's diagnosed conditions, her report was of limited probative value.

Appellant also submitted multiple progress notes from the VA Medical Center. These reports show that appellant had preexisting issues with his right knee as evidenced by the MRI scan by Dr. Kowalec taken on June 18, 2014, and the fact that appellant underwent a right knee diagnostic arthroscopy and medial meniscus partial meniscectomy on November 15, 2014. These reports are of limited probative value as none of the physicians from the VA Medical

[11] 5 U.S.C. § 8101(2).

[12] *See Jay K. Tomokiyo*, 51 ECAB 361 (2000).

[13] 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. 5 U.S.C. § 8102(2); *J.G.*, Docket No. 15-251 (issued April 13, 2015); *A.C.*, Docket No. 08-1453 (issued November 18, 2008) (records from a physical therapist do not constitute competent medical opinion in support of causal relation, as physical therapists are not considered physicians as defined under FECA).

[14] *L.W.*, Docket No. 16-1317 (issued June 21, 2017).

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

[16] *K.W.*, Docket No. 17-0205 (issued June 12, 2017).

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

Center provided a rationalized opinion explaining how the February 3, 2015 accepted employment incident caused an injury. Dr. Jain-Ahuja mentioned appellant's employment incident, noted active problems including osteoarthritis, and noted the prior surgery of November 15, 2014. Although Dr. Jain-Ahuja indicated that appellant sustained injuries to his back and knees during the February 3, 2015 fall, she did not provide any rationalized medical opinion explaining causal relationship. A conclusion without the necessary rationale explaining how and why the physician believes that a claimant's accepted employment incident could result in a diagnosed condition is not sufficient to meet a claimant's burden of proof.[18] Dr. Antoine noted the employment incident and injury to appellant's knees, but offered no firm medical diagnosis and no opinion regarding causal relationship. Lacking a firm diagnosis and medical rationale on the issue of causal relationship, Dr. Antoine's report is insufficient to establish that appellant sustained an employment-related injury.[19]

Finally, Dr. Basch, in his December 15, 2016 report, notes the February 3, 2015 employment incident and diagnoses of chronic cervical and lumbar strains and bilateral knee internal derangement. However, he provided no rationalized opinion on causal relationship, and his opinion is, therefore, insufficient to establish that the February 3, 2015 fall caused or aggravated a medical diagnosis.[20]

An award of compensation may not be based on surmise, conjecture, speculation, or appellant's belief of causal relationship.[21] Appellant has failed to submit rationalized medical evidence sufficient to meet his burden of proof to establish an employment-related 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 his burden of proof to establish a traumatic injury causally related to the accepted February 3, 2015 employment incident.

[18] *J.S.*, Docket No. 14-818 (issued August 7, 2014).

[19] *See E.S.*, Docket No. 16-0267 (issued May 17, 2016).

[20] *Id.*

[21] *John D. Jackson*, 55 ECAB 465 (2004); *William Nimitz*¸ 30 ECAB 57 (1979).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 9, 2017 is affirmed.

Issued: November 16, 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