United States Department of Labor
Employees' Compensation Appeals Board

A.C., Appellant	)	
and	)	**Docket No. 16-0452**
	)	**Issued: October 27, 2017**
DEPARTMENT OF HOMELAND SECURITY, CUSTOMS & BORDER PROTECTION, Van Buren, ME, Employer	)	

Appearances:
Theodore M. Smith, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On January 11, 2016 appellant, through counsel, filed a timely appeal from an August 19, 2015 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.[3]

[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.*

[3] The record provided the Board includes evidence received after OWCP issued its August 19, 2015 decision. The Board's review is limited to the evidence that was before OWCP at the time of its final decision. Therefore, the Board lacks jurisdiction to review this additional evidence for the first time on appeal. 20 C.F.R. § 501.2(c)(1).

ISSUE

The issue is whether appellant met his burden of proof to establish a left shoulder condition causally related to the February 19, 2014 employment incident.

FACTUAL HISTORY

On February 24, 2014 appellant, then a 51-year-old automotive mechanic, filed a traumatic injury claim (Form CA-1) alleging a left shoulder condition that allegedly arose in the performance of duty on February 19, 2014. He explained that when he went to push the close button on the door controller, he felt his left shoulder lock up as he lowered his arm back to his side. Appellant stopped work on February 19, 2014.

Dr. Daniel P. Harrigan, Board-certified in emergency medicine, examined appellant on February 19, 2014 and noted a history of pain in the left shoulder after abducting the left arm. He also noted a concurrent or preexisting history of left shoulder calcific tendinitis. Physical findings included tenderness and painful range of motion in the left shoulder. Dr. Harrigan diagnosed left shoulder bicipital tendinitis. On the form report (Form CA-20), he checked a box marked "yes" in response to the question of whether he believed that the condition was caused or aggravated by the employment activity. Dr. Harrigan advised that appellant was totally disabled from February 19 to 23, 2014, and would be able to resume regular work on or after February 23, 2014.

A February 22, 2014 left shoulder x-ray revealed no acute fracture or dislocation, calcific bursitis or calcific tendinopathy, and a large spur under the surface distal clavicle which could be associated with supraspinatus tears.

In February 22, 2014 reports, Dr. Harrigan noted that appellant's chief complaint was an injury to the left shoulder. He noted that appellant indicated that the injury occurred three days ago at work as a twisting injury. Dr. Harrigan examined appellant's left shoulder and found mild tenderness in the anterior and lateral aspect of the shoulder and bicipital tendon along with limited range of motion to pain. He diagnosed left shoulder tendinitis.

OWCP received reports dated February 24 and April 7, 2014 from Dr. Mark N. Perlmutter, an orthopedic surgeon, who noted that appellant's chief complaint was left shoulder pain. In the February 24, 2014 attending physician's report (Form CA-2), Dr. Perlmutter noted a February 19, 2014 history of injury of left shoulder pain and limited range of motion after reaching up to push a button for the garage door. His findings/diagnoses included partially torn tendon, impingement, left shoulder occupational bursitis, and calcific tendinitis. Dr. Perlmutter checked a box marked "yes" on the form indicating that the condition was caused or aggravated by an employment activity, but did not provide an explanation regarding causal relationship. He recommended modified duty with no overhead or over the shoulder work and no lifting with the left arm/shoulder.

In separate treatment notes also dated February 24, 2014, Dr. Perlmutter noted that appellant was originally injured on August 19, 2010, and reinjured on February 19, 2014. He described the trauma as a "twisting injury with quick motion." Dr. Perlmutter related that

appellant indicated that his shoulder suddenly locked up and he heard a popping sound in the shoulder. Appellant also reported a snapping and clicking sensation in the shoulder, and noted that his shoulder would catch during movement. There was also a sensation of something floating in the shoulder. Appellant advised that the shoulder could not be dislocated voluntarily. Dr. Perlmutter diagnosed left shoulder occupational bursitis and calcific tendinitis. In his April 7, 2014 follow-up treatment notes, he essentially reiterated the previously reported history and assessment. In a similarly dated attending physician's report (Form CA-20), Dr. Perlmutter noted "regular duty" in the remarks section.

In a July 2, 2014 follow-up report, Dr. Perlmutter diagnosed left shoulder occupational bursitis, calcific tendinitis, and left shoulder strain. He imposed an upper extremity work restriction until appellant's next follow-up appointment in October 2014.

In an October 2, 2014 report, Dr. Perlmutter diagnosed left shoulder strain, calcific tendinitis, and occupational bursitis of the left shoulder. He completed a work capacity evaluation and checked the box marked "yes" in response to whether appellant was capable of performing his usual job.

In a November 17, 2014 development letter, OWCP informed appellant of the type of evidence needed to support his claim and requested that he submit such evidence within 30 days. It explained that it was unclear how he had injured his left arm pushing the close button of a door controller. OWCP further noted that the medical evidence of record failed to show how the diagnosed conditions (left shoulder strain, tendinitis, impingement, and occupational bursitis) were either caused or aggravated by the February 19, 2014 work injury.

In a November 12, 2014 report, Dr. Perlmutter diagnosed left shoulder strain, calcific tendinitis, and occupational bursitis of the left shoulder. He opined that, to a reasonable degree of medical certainty, appellant's left shoulder calcific tendinitis was directly caused by his work-related left shoulder strain. Dr. Perlmutter explained that the strain functionally disrupted the rotator cuff tendon, which healed with excessive calcifications which were currently symptomatic. He related that they had placed restrictions on appellant's work duties to include no reaching above the left shoulder.

In a December 1, 2014 statement, responding to OWCP's request for additional information, appellant noted that the door controller was located beside the garage door and he had to reach to the side as opposed to overhead to reach it. He noted that his shoulder had been bothering him since the first injury at work on August 19, 2010, while pulling an "ATV" crank in order to start the machine. Appellant also noted that he injured his left shoulder at work on March 5, 2013 when lifting a tire at work. He responded "no" with regard to whether he suffered from any traumatic events outside work. Appellant indicated that he lost time from work from February 19 through 23, 2014. He responded that he had worked full-time duties thereafter, "although in pain."

OWCP received part of an attending physician's report from June 2013 pertaining to an incident when appellant was lifting a tire at work as well as notes from a physician assistant.

By decision dated December 19, 2014, OWCP denied appellant's claim because he failed to establish that the diagnosed left shoulder conditions were causally related to the February 19, 2014 employment incident.

On January 9, 2015 appellant requested an oral hearing, which was held on July 8, 2015.

In a December 31, 2014 report, Dr. Perlmutter advised that appellant had not sought medical treatment during the 10-month period that preceded the February 19, 2014 injury. He advised that appellant's shoulder was stable and the new injury caused weakness of the rotator cuff as shown on examination and weakness of internal and external rotation. Dr. Perlmutter opined that this injury of February 19, 2014 has caused increased pain with new weakness and that the injury was stable until injury on February 19, 2014.

In a March 31, 2015 report, Dr. Jean Pierre Michaud, an orthopedic surgeon, noted that appellant had a work-related injury dating back to 2010. He related the history which included that a magnetic resonance imaging (MRI) scan revealed some elements of inflammation, degeneration, capsulitis, and tendinitis. Dr. Michaud explained that the MRI scan was performed on February 13, 2015 and revealed acromioclavicular (AC) joint arthritis, degenerative shoulder arthritis, glenohumeral joint, rotator cuff tendinitis, partial injury, and no full-thickness tear along with intraarticular loose bodies. He indicated that appellant's range of motion was 90 percent normal now and they would avoid surgery for now.

In his report dated July 16, 2015, Dr. Michaud advised that appellant was last seen and evaluated on June 2, 2015. He noted that appellant had evidence of chronic AC joint arthritis, chronic rotator cuff pathology, glenohumeral arthritis, and a chronic impingement syndrome. Dr. Michaud advised that x-rays revealed a large inferior spur and degeneration and arthritis in the glenohumeral joint, AC arthritis, and inferior spur formation "predisposing [appellant] to chronic impingement syndrome." He also related that appellant had a left shoulder MRI scan on February 13, 2015 which revealed AC joint and glenohumeral joint arthritis as well as multiple loose bodies in the joint. Dr. Michaud advised that it also showed a partial thickness injury and tearing to the rotator cuff, but no full-thickness tear was noted. He noted that appellant had ongoing impingement and subacromial inflammation, subacromial bursitis, and rotator cuff tendinitis. Dr. Michaud explained that "any at, or above shoulder level activity or repetitive movement requiring heavy demand utilizing this shoulder can and most likely will exacerbate the patient's impingement, pain, swelling and dysfunction." He indicated that appellant had "a preexisting condition of tendinitis, subacromial bursitis, AC joint arthritis that is being aggravated with any at or above shoulder level activity."

By decision dated August 19, 2015, an OWCP hearing representative affirmed the December 19, 2014 decision. He explained that there was no rationalized medical evidence sufficient to establish causal relationship.

LEGAL PRECEDENT

A claimant 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, 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.[5]

To determine if an employee sustained a traumatic 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 that must be considered in conjunction with one another. The first component is whether the employee actually experienced the employment incident that allegedly occurred.[6] The second component is whether the employment incident caused a personal injury.[7] An employee may establish that an injury occurred in the performance of duty as alleged, but fail to establish that the disability or specific condition for which compensation is being claimed is causally related to the injury.[8]

The fact that a condition manifests itself during a period of employment is insufficient to establish causal relationship.[9] Temporal relationships alone will not suffice.[10] Entitlement to FECA benefits may not be based on surmise, conjecture, speculation, or on the employee's own belief of a causal relationship.[11]

In any case where a preexisting condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation, acceleration, or precipitation, the physician must provide a rationalized medical opinion that differentiates between the effects of the work-related injury or disease and the preexisting condition.[12]

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[4] *See supra* note 2.

[5] 20 C.F.R. § 10.115(e), (f); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996).

[6] *Elaine Pendleton*, 40 ECAB 1143 (1989).

[7] *John J. Carlone*, 41 ECAB 354 (1989). Causal relationship is a medical question that generally requires rationalized medical opinion evidence to resolve the issue. *Robert G. Morris*, 48 ECAB 238 (1996). A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factor(s) must be based on a complete factual and medical background. *Victor J. Woodhams*, 41 ECAB 345, 352 (1989). Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty, and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factor(s). *Id.*

[8] *Shirley A. Temple*, 48 ECAB 404, 407 (1997).

[9] 20 C.F.R. § 10.115(e).

[10] *See D.I.*, 59 ECAB 158, 162 (2007).

[11] *See M.H.*, Docket No. 16-0228 (issued June 8, 2016).

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013).

Certain healthcare providers such as physician assistants, nurse practitioners, physical therapists, and social workers are not considered physicians as defined under FECA.[13] Consequently, their medical findings and/or opinions will not suffice for purposes of establishing entitlement to FECA benefits.[14]

ANALYSIS

The Board finds that appellant has failed to establish that his claimed left shoulder condition was causally related to the accepted February 19, 2014 employment incident. The medical evidence of record contains no reasoned explanation of how the specific employment incident on February 19, 2014 caused or aggravated an injury.[15] The Board notes that this is particularly important as appellant has a history of prior work injuries to his shoulder.

In the February 19, 2014 attending physician's report, Dr. Harrigan noted that appellant had pain in the left shoulder after abducting the left arm. He found tenderness and painful range of motion in the left shoulder. Dr. Harrigan checked the box marked "yes" in response to whether he believed that the condition was caused or aggravated by the employment incident. The checking of a box marked "yes" in a form report, without additional explanation or rationale, is insufficient to establish causal relationship.[16]

In a February 22, 2014 report, Dr. Harrigan noted that appellant's chief complaint was an injury to the left shoulder which occurred three days prior at work, as a twisting injury. He diagnosed tendinitis of the left shoulder. However, this report is of limited probative value on the relevant issue of the present case in that it does not contain an opinion on causal relationship.[17]

Dr. Perlmutter provided reports dated February 24 and April 7, 2014 and noted that the chief complaint was left shoulder pain. He also referenced the original left shoulder injury from August 19, 2010 and advised that appellant was reinjured on February 19, 2014 due to trauma from a twisting injury with quick motion. Dr. Perlmutter diagnosed calcific tendinitis, left shoulder occupational bursitis, and left shoulder strain. However, he did not provide an opinion on causal relationship.[18] In the attending physician's report, Dr. Perlmutter explained that

[13] 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t).

[14] *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. *Supra* note 12 at Chapter 2.805.3a(1).

[15] *See George Randolph Taylor*, 6 ECAB 986, 988 (1954) (where the Board found that a medical opinion not fortified by medical rationale is of little probative value).

[16] *Calvin E. King*, 51 ECAB 394 (2000).

[17] *See Charles H. Tomaszewski*, 39 ECAB 461, 467-68 (1988) (finding that medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship).

[18] *Id.*

appellant had left shoulder pain and limited range of motion from reaching up to push a button for the garage door. He checked the box marked "yes" in response to whether he believed the condition was caused or aggravated by an employment activity. Dr. Perlmutter also provided an October 2, 2014 report in which he diagnosed left shoulder strain, calcific tendinitis, and occupational bursitis of the left shoulder. As noted above, the checking of a box marked "yes" in a form report, without additional explanation or rationale, is insufficient to establish causal relationship.[19]

In the November 12, 2014 report, Dr. Perlmutter diagnosed left shoulder strain, calcific tendinitis, and occupational bursitis of the left shoulder. He opined that, to a reasonable degree of medical certainty, appellant's left shoulder calcific tendinitis was directly caused by appellant's work-related left shoulder strain. Dr. Perlmutter explained that the strain functionally disrupted the rotator cuff tendon, which healed with excessive calcifications that were currently symptomatic. The Board notes that he did not explain how the activities of pushing a button on the door controller would cause these conditions. This is also especially important as appellant had preexisting shoulder conditions. Dr. Perlmutter failed to provide sufficient medical reasoning, or rationale, explaining how this work incident caused or aggravated a particular diagnosed condition.[20] Similarly, he provided a December 31, 2014 report in which he indicated that appellant's shoulder was stable and the new injury caused weakness of the rotator cuff as shown on examination and weakness of internal and external rotation. Dr. Perlmutter opined that this injury of February 19, 2014 has caused increased pain with new weakness and the injury was stable until injury on February 19, 2014. However, he did not explain how the work incident caused or aggravated a particular diagnosed condition.

In his March 31, 2015 report, Dr. Michaud noted that appellant had a work-related injury dating back to 2010 and had a history which included some elements of inflammation, degeneration, capsulitis, and tendinitis. In his report dated July 16, 2015, he advised that appellant was last seen and evaluated on June 2, 2015. Dr. Michaud noted that appellant had evidence of a chronic AC joint arthritis, chronic rotator cuff pathology, glenohumeral arthritis, and a chronic impingement syndrome. He advised that x-rays revealed a large inferior spur and degeneration and arthritis in the glenohumeral joint, AC arthritis, and inferior spur formation predisposing him to chronic impingement syndrome. Dr. Michaud also related that appellant had a left shoulder MRI scan on February 13, 2015 which revealed AC joint and glenohumeral joint arthritis as well as multiple loose bodies in the joint. He advised that it also showed a partial thickness injury and tearing to the rotator cuff, but no full-thickness tear was noted. Dr. Michaud noted that appellant had ongoing impingement and subacromial inflammation, subacromial bursitis, and rotator cuff tendinitis. He explained that "any at, or above shoulder level activity or repetitive movement requiring heavy demand utilizing this shoulder can and most likely will exacerbate the patient's impingement, pain, swelling and dysfunction." Dr. Michaud indicated that appellant's preexisting condition of tendinitis, subacromial bursitis, and AC joint arthritis was being aggravated with any at or above shoulder level activity. The Board finds that to the

[19] *See supra* note 16.

[20] *See supra* note 15.

extent that he is asserting that a return to work might cause further injury, the Board has held that fear of future injury is not compensable.[21]

Appellant also submitted physical therapy treatment records, notes from a physician assistant, as well as nursing notes. However, these healthcare providers are not considered physicians under FECA, and therefore, their respective reports will not suffice for purposes of establishing entitlement to FECA benefits.[22]

Because the medical reports submitted by appellant failed to address how the February 19, 2014 employment incident caused or aggravated a left shoulder condition, these reports are of limited probative value and are insufficient to establish that the February 19, 2014 employment incident caused or aggravated a specific injury.[23]

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 failed to meet his burden of proof to establish a left shoulder condition causally related to the February 19, 2014 employment incident.

[21] *I.J.*, 59 ECAB 408 (2008).

[22] *See supra* notes 13 and 14.

[23] *See Linda I. Sprague*, 48 ECAB 386, 389-90 (1997).

ORDER

IT IS HEREBY ORDERED THAT the August 19, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: October 27, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board