United States Department of Labor
Employees' Compensation Appeals Board

K.E., Appellant	)	
and	)	**Docket No. 17-1216**
	)	**Issued: February 22, 2018**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Jackson, MS, Employer	)	

Appearances:
Appellant, pro se
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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On May 15, 2017 appellant filed a timely appeal of a March 22, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether OWCP properly terminated appellant's wage-loss compensation and medical benefits, effective November 13, 2016; and (2) whether appellant met her burden of proof to establish residuals or continuing disability causally related to the accepted injury after November 13, 2016.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On June 16, 2009 appellant, then a 43-year-old respiratory therapist, filed a traumatic injury claim (Form CA-1) alleging that on June 13, 2009 she injured her right arm and wrist while lifting and pulling oxygen tanks and a "dirty equipment/oxygen concentrator." OWCP accepted appellant's claim for right wrist sprain and later expanded the claim to include right shoulder sprain. Appellant stopped work on June 18, 2009 and returned to limited-duty work on June 30, 2009. She stopped work again on December 21, 2009 and returned to a full-time limited-duty assignment on March 1, 2010.[2]

Appellant came under the treatment of Dr. William B. Geissler, a Board-certified orthopedist, on July 20, 2009, for right wrist and shoulder pain. She reported developing pain on June 13, 2009 while lifting heavy equipment. Appellant also had a previous fall on June 12, 2007. Dr. Geissler diagnosed right torn triangular fibrocartilage complex and rotator cuff tendinitis. On August 19, 2009 he injected lidocaine into the right shoulder and diagnosed right rotator cuff tendinitis. Dr. Geissler recommended physical therapy. An August 5, 2009 magnetic resonance imaging (MRI) scan of the right shoulder revealed mild acromioclavicular joint degenerative changes, mild insertional tendinopathy of the supraspinatus, infraspinatus and subscapularis, and mild subdeltoid and subacromial bursitis. A right wrist MRI scan showed two small ganglion cysts and mild degenerative arthritic changes.

On October 28, 2009 Dr. Geissler noted that appellant presented with no improvement in her shoulder after physical therapy and an injection. He diagnosed persistent right rotator cuff tendinitis and possible ulnar abutment syndrome and recommended surgery. On December 22, 2009 Dr. Geissler performed an authorized arthroscopic right shoulder decompression.[3]

Appellant continued seeing Dr. Geissler from June 21, 2010 to August 17, 2011 who noted that appellant was improving postoperatively. Dr. Geissler noted that appellant reached maximum medical improvement (MMI) on June 21, 2010. He advised that she underwent a functional capacity evaluation on June 15, 2010 which revealed that she could work full time with restrictions of lifting to the waist 17 pounds occasionally, lifting waist to eye level 17 pounds occasionally, two-handed carrying 22 pounds occasionally and pushing and pulling 25 pounds occasionally. On May 9, 2011 appellant presented with a new injury to her right arm. She reported putting paper into the copier when she fell backwards with her arms extended. Dr. Geissler diagnosed cervical spondylosis and status post decompression. A May 23, 2011 cervical spine MRI scan revealed disc osteophyte complex at C5-6 with left foraminal disc protrusion and small posterior disc osteophyte at C4-5 and C6-7 without cord compression.

Appellant began treatment with Dr. Mahesh Mehta, a Board-certified anesthesiologist. On April 26, 2012 Dr. Mehta treated appellant for chronic pain. He diagnosed cervical disc degenerative disease, cervicalgia, and cervical radiculopathy.

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[2] Appellant received wage-loss compensation for periods that she did not work.

[3] On April 8, 2010 OWCP made a preliminary determination that appellant was at fault in receiving a $1,254.04 overpayment because she was paid compensation from March 1 to 13, 2010 after she had returned to work. On May 24, 2010 it finalized the overpayment determination.

On August 13, 2013 OWCP referred appellant to Dr. B. Thomas Jeffcoat, a Board-certified orthopedist for a second opinion, to determine if the accepted conditions had resolved. In a September 19, 2013 report, Dr. Jeffcoat indicated that he reviewed the medical record and examined appellant. He noted findings on examination of full range of motion of her neck, right shoulder, elbows, wrists, and digits, intact motor function, and intact sensation. The right shoulder had tenderness at the posterior medial border. Dr. Jeffcoat opined that appellant's right wrist and right shoulder sprain and right rotator cuff tendinitis resolved based on the medical records, radiological studies, and the medical evaluation conducted. He indicated that, after reviewing appellant's medical records, the statement of accepted facts (SOAF) and the requirements of the modified assignment of a respiratory therapist, he opined that appellant could physically perform the work level.

Dr. Mehta, on July 23, 2014, diagnosed cervical facet syndrome and tendinosis. He indicated that the accepted conditions were still present and disabling. Dr. Mehta noted that appellant's aggravation of a preexisting condition returned to preinjury status. He advised that appellant could work with a lifting restriction of 20 pounds. On September 23, 2015 Dr. Mehta diagnosed arthrosis of the right shoulder, cervical radiculopathy, myofascial pain, shoulder enthesopathy, cervicalgia, cervical disc disease, and right shoulder pain. He performed an injection into the major bursa/joint. In a return to work slip dated September 23, 2015, Dr. Mehta returned appellant to work on September 26, 2015 with no restrictions.

On August 21, 2016 OWCP referred appellant to Dr. Daniel P. Dare, a Board-certified orthopedist, to determine if the accepted conditions had resolved. In an August 30, 2016 report, Dr. Dare indicated that he reviewed a SOAF and the records provided and examined appellant. He noted findings on examination of the right wrist which revealed slow complete range of motion, there was complete grip strength, and no neurologic deficits. Examination of the right shoulder revealed forward elevation of 160 degrees, abduction of 125 degrees and external rotation to L3, intact supraspinatus, infraspinatus, teres minor and subscapularis, no tenderness over the acromioclavicular joint, and negative labral signs. Dr. Dare diagnosed history of arthroscopic decompression for tendinitis and frozen shoulder, chronic pain from other sources including the cervical spine, and myofascial pain. He opined that both the right shoulder sprain and right wrist sprain resolved without residuals. With regard to whether appellant could perform her date-of-injury position as a respiratory therapist without restrictions Dr. Dare indicated that after reviewing the physical requirements of the modified assignment appellant was capable of performing that job with lifting limited to 50 pounds. He noted that appellant's current treatment with Dr. Mehta was for chronic pain which did not appear to be related to the accepted conditions of shoulder and wrist sprain.

On September 28, 2016 OWCP proposed to terminate appellant's wage-loss compensation and medical benefits, finding that Dr. Dare's report established no continuing residuals of her accepted conditions. It allowed her 30 days in which to respond.

In a statement dated October 17, 2016, appellant requested an extension of time to respond so that she could obtain medical documentation from Drs. Geissler, Mehta, and other providers. She disagreed with Dr. Dare's opinion that she could return to full duty as a respiratory therapist. Appellant indicated that she waited over two hours to see Dr. Dare because of a medical emergency and he spent less than five minutes evaluating her. She noted that the

verbal examination was brief and he performed a minimal physical examination and only asked her to squeeze his fingers and to hold her arm up. Appellant noted that Dr. Dare incorrectly indicated that she was 50 years old and 5'10" inches tall. She advised that prior to her work-related accident she was not on medications, she was not hypertensive, and she was not diagnosed with depression, anxiety or acute or chronic pain. Appellant indicated that the work injury effected activities of daily living as she lived with chronic pain. She requested compensation for September 22, 2016 when she received an injection.[4]

Appellant submitted a return to work note prepared by a registered nurse dated September 22, 2016 who reported that she could return to work on September 26, 2016. In a note dated September 22, 2016, a customer care representative noted that appellant was treated in the pain management clinic on September 22, 2016 and she could return to work on September 23, 2016.

By decision dated November 2, 2016, OWCP terminated appellant's wage-loss compensation and medical benefits, effective November 13, 2016.

Appellant submitted a September 22, 2016 procedure note from Dr. Mehta for an injection into the major bursa/joint. Dr. Mehta diagnosed right shoulder pain and right shoulder arthrosis. On September 30, 2016 he treated appellant for right shoulder pain. Appellant presented with increased shoulder pain after a right-sided shoulder injection. Dr. Mehta noted findings of diffuse tenderness around the shoulder and scapula, limited range of motion, and tenderness along the right cervical spinal musculature. He diagnosed right shoulder pain, right arthrosis of the shoulder, and right shoulder enthesopathy. Dr. Mehta opined that the increased pain after the injection may have been the result of tendon irritation or penetration. He recommended conservative treatment.

On December 6, 2016 Dr. Geissler evaluated appellant's right shoulder and wrist. He noted last treating appellant in 2011. Dr. Geissler indicated that appellant fell onto a tile floor in June 2006 while at work and developed adhesive capsulitis and had shoulder surgery. He noted appellant's current complaints of wrist pain and palm pain. Appellant related that she fell and jammed her wrist when she was injured. Right shoulder findings included no sign of adhesive capsulitis, breakaway strength with abduction and flexion, and pain localized over the acromioclavicular joint. With regard to the right hand there was no atrophy of the thenar or hypothenar eminence, no Tinel's sign, negative Phalen's test, and good capillary refill. Dr. Geissler diagnosed status post debridement of adhesive capsulitis and wrist pain. He injected her shoulder with lidocaine. On December 27, 2016 appellant requested reconsideration. In a letter dated December 20, 2016, she requested reconsideration of the termination of medical benefits. Appellant indicated that her claims examiner assured her that her medical benefits would not be terminated and that she could continue to seek medical attention for her injuries. She indicated that she had scheduled doctors' appointments related to her June 13, 2009 injury which were approved by OWCP. Appellant contended that her chronic pain symptoms had not resolved and she would need continued medical care for the rest of her life.

[4] On September 27, 2016 appellant filed a claim for compensation (Form CA-7) for leave without pay, for September 22 and 23, 2016. On December 5, 2016 OWCP denied her request for compensation for September 22 and 23, 2016. Appellant has not appealed this decision.

Appellant submitted a December 20, 2016 report from Dr. Marion Stanton Ward, a Board-certified orthopedist, who treated her for right shoulder and neck pain. Dr. Ward noted appellant's history was significant for a left C5-6 disc herniation with neck pain and right arm symptoms. Appellant reported pain around the deltoid and anterior and posterior shoulder and medial border of the scapula. Dr. Ward noted findings of intact motor strength bilaterally, normal and symmetric reflexes, no range of motion deficits, no effusions or crepitus in the extremities, and positive right Neer's impingement test. Upon review of December 20, 2016 and June 22, 2011 cervical spine x-rays he noted progression of degenerative changes at C5-6. Dr. Ward diagnosed right shoulder and neck pain and left paracentral disc herniation at C5-6. He opined that appellant had mild chronic neck pain related to degenerative changes at C5-6 with significant shoulder symptoms. Dr. Ward noted that appellant was placed at MMI on December 5, 2012 with a 35-pound carrying limit, 20-pound lifting limit related to her back and limited overhead activity to less than one hour per day.

In a report dated January 4, 2017, Dr. Geissler noted that appellant underwent a right wrist MRI scan which was normal.[5] He noted right hand findings of no atrophy of the thenar or hypothenar eminence and negative Tinel's and Phalen's signs. Dr. Geissler diagnosed status post debridement adhesive capsulitis and wrist pain. He concurred in Dr. Ward's work restrictions of December 20, 2016.

By decision dated March 22, 2017, OWCP denied modification of its November 2, 2016 decision.

LEGAL PRECEDENT -- ISSUE 1

Once OWCP accepts a claim and pays compensation, it has the burden of justifying modification or termination of an employee's benefits. After it has determined that an employee has disability causally related to his or her federal employment, it may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.[6] The right to medical benefits for an accepted condition is not limited to the period of entitlement to compensation for disability. To terminate authorization for medical treatment, OWCP must establish that appellant no longer has residuals of an employment-related condition, which require further medical treatment.[7]

ANALYSIS -- ISSUE 1

The Board finds that the opinion of Dr. Dare represents the weight of the evidence and establishes that appellant's work-related conditions have resolved. Dr. Dare reviewed the medical record, examined appellant, and indicated that she did not have residuals from the condition of right shoulder sprain and right wrist sprain and that she could return to her regular

[5] An MRI scan of the right wrist dated December 20, 2016 revealed a ganglion cyst along the dorsal aspect of the wrist and normal carpal tunnel.

[6] *Kenneth R. Burrow*, 55 ECAB 157 (2003).

[7] *Furman G. Peake*, 41 ECAB 361 (1990).

duties. He also concluded that she was capable of performing the duties of the modified job assignment with a lifting restriction and noted that the pain she experienced was not employment related. There is no contemporaneous medical evidence of equal weight supporting appellant's claim for continuing disability and medical residuals.

Appellant submitted a return to work note prepared by a registered nurse dated September 22, 2016 who indicated that appellant could return to work on September 26, 2016. However, the Board has held that treatment notes signed by a nurse are not considered medical evidence as nurses are not considered physicians under FECA.[8] Also submitted was a note dated September 22, 2016 from a customer care representative who noted that appellant was treated on September 22, 2016 and that she could return to work on September 23, 2016. There is no evidence that the customer care representative is a physician. Medical documents not signed by a physician and lacking proper identification do not constitute probative medical evidence.[9]

For these reasons, OWCP met its burden of proof in terminating appellant's wage-loss compensation and medical benefits.

LEGAL PRECEDENT -- ISSUE 2

As OWCP met its burden of proof to terminate appellant's compensation benefits, the burden shifts to appellant to establish continuing disability causally related to his or her accepted employment injury.[10] To establish causal relationship between the claimed disability and the employment injury, appellant must submit rationalized medical opinion evidence based on a complete factual and medical background supporting such causal relationship.[11]

ANALYSIS -- ISSUE 2

The Board finds that appellant has not established that she has any continuing residuals or disability due to her accepted conditions beginning November 13, 2016.

After the termination of benefits, appellant submitted a September 22, 2016 procedure note from Dr. Mehta for an injection into the major bursa/joint. Dr. Mehta diagnosed right shoulder pain and right shoulder arthrosis. On September 30, 2016 he treated appellant for increased shoulder pain following a right-sided shoulder injection. Dr. Mehta diagnosed right

[8] *See David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006) (lay individuals such as physician assistants, nurses and physical therapists are not competent to render a medical opinion under FECA); 5 U.S.C. § 8101(2) (this subsection defines a "physician" as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law).

[9] *See R.M.*, 59 ECAB 690 (2008); *Bradford L. Sullivan*, 33 ECAB 1568 (1982) (where the Board held that 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 FECA). *See also* 5 U.S.C. § 8101(2) (defines the term physician as used in FECA).

[10] *See Joseph A. Brown, Jr.*, 55 ECAB 542 (2004); *Manuel Gill*, 52 ECAB 282 (2001).

[11] *Daniel F. O'Donnell, Jr.*, 54 ECAB 456 (2003).

shoulder pain, right arthrosis of the shoulder and right shoulder enthesopathy. He opined that the increased pain after the injection may have been due to an irritated tendon that may have been penetrated. However, Dr. Mehta failed to provide a specific or a rationalized opinion as to how appellant's current condition was causally related the accepted conditions.[12]

Appellant submitted a report from Dr. Geissler dated December 6, 2016 who noted last treating appellant in 2011. He reported that appellant fell onto a tile floor in June 2006 while at work and developed adhesive capsulitis and underwent shoulder surgery. Dr. Geissler diagnosed status post debridement of adhesive capsulitis and wrist pain. Similarly, in a report dated January 4, 2017, he diagnosed status post debridement adhesive capsulitis and wrist pain. Dr. Geissler continued appellant's work restrictions of December 20, 2016. However, he failed to accurately note a history of injury at issue in the present claim as he referenced a June 2006 falling incident instead of the accepted June 13, 2009 employment injury.[13] Further, Dr. Geissler did not specifically address how any continuing condition was causally related to the accepted employment injury. Additionally his report did not include a rationalized opinion regarding causal relationship between appellant's current condition and her accepted conditions.

Appellant submitted a December 20, 2016 report from Dr. Ward who treated her for right shoulder and neck pain. She reported pain around the anterior and posterior shoulder including the medial border of the scapula. Dr. Ward diagnosed right shoulder and neck pain, and left paracentral disc herniation at C5-6. He opined that appellant had mild chronic neck pain related to degenerative changes at C5-6 with significant shoulder symptoms. However, Dr. Ward's report is insufficient to establish the claim as he did not provide a history of injury[14] or include a rationalized opinion regarding the causal relationship between appellant's current condition and her accepted conditions.[15] Moreover, OWCP never accepted that appellant sustained left paracentral disc herniation at C5-6 or degenerative changes at C5-6 as a result of her work injury and there is no medical rationalized evidence to support such a conclusion.[16]

Other medical evidence submitted, such as reports of diagnostic testing, are of limited probative value because they do not contain a physician's explanation regarding how any diagnosed medical condition is due to appellant's June 13, 2009 work injury.[17]

[12] *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).

[13] *See Leonard J. O'Keefe*, 14 ECAB 42, 48 (1962) (where the Board held that medical opinions based upon an incomplete history have little probative value).

[14] *Frank Luis Rembisz*, 52 ECAB 147 (2000) (medical opinions based on an incomplete history or which are speculative or equivocal in character have little probative value).

[15] *See supra* note 13.

[16] *Alice J. Tysinger*, 51 ECAB 638 (2000).

[17] *See S.E.*, Docket No. 08-2214 (issued May 6, 2009) (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).

Consequently, appellant has not established that she has any employment-related condition or disability after November 2, 2016.

On appeal appellant asserts that OWCP improperly terminated her compensation benefits as she continued to have chronic pain. She further alleged that Dr. Dare only evaluated her for five minutes. The Board finds that the August 30, 2016 report from Dr. Dare provided findings on examination, as noted, that supported his conclusion that the accepted conditions had resolved. Dr. Dare found no clinical findings of residuals or disability causally related to the accepted right wrist and right shoulder sprain. He opined that both the right shoulder sprain and right wrist sprain resolved without residuals. The reports from Drs. Mehta, Geissler and Ward, do not sufficiently explain how any continuing condition or disability was causally related to the accepted employment 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 OWCP has met its burden of proof to terminate benefits, effective November 13, 2016. The Board further finds that appellant has not established continuing residuals or disability after November 13, 2016.

ORDER

IT IS HEREBY ORDERED THAT the March 22, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 22, 2018
Washington, DC

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

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

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