United States Department of Labor
Employees' Compensation Appeals Board

R.H., Appellant	)	
and	)	**Docket No. 17-1405**
	)	**Issued: February 7, 2018**
DEPARTMENT OF THE ARMY, CORPS OF ENGINEERS, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, 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
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 14, 2017 appellant, through counsel, filed a timely appeal from a March 2, 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 to consider the merits of the case.

ISSUE

The issue is whether appellant met his burden of proof to establish an injury causally related to the accepted July 15, 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 July 16, 2015 appellant, then a 49-year-old administrative support assistant, filed a traumatic injury claim (Form CA-1) alleging that, on July 15, 2015, he injured his right hand and leg when he was in an employment-related motor vehicle accident. He alleged that a vehicle attempted to make an illegal U-turn directly in front of his government vehicle thereby causing him to strike the vehicle. The claim form did not indicate whether appellant had stopped work.

In a July 16, 2015 report, Dr. Elizabeth Elson, a Board-certified radiologist, noted that appellant was treated on that date in the Emergency Department at Kennedy Health System. She interpreted an x-ray of appellant's cervical spine as showing possible cervical spasm with no acute fracture or subluxation. With regard to appellant's lumbosacral spine, Dr. Elson noted no acute fracture or subluxation. She noted no displaced fracture of the right foot. An x-ray of appellant's hand showed linear calcific density projecting along the ulnar aspect of the first metatarsal -- phalangeal joint of uncertain etiology, but otherwise, no displaced fractures or dislocation was found. X-rays of the bilateral knees showed no acute fracture or dislocation and no significant effusion. The record also contains unsigned discharge instructions from the Kennedy Health System, which noted that appellant was treated by Dr. Neelesh Parikh, an osteopath, for cervical sprain, lumbar sprain/stain, hand contusion, and lower extremity contusion.

In a July 28, 2015 note, Dr. Rocco F. Caveng, Jr., an osteopath, requested that appellant be excused from work from July 27 through August 7, 2015.

By letter dated July 29, 2015, OWCP informed appellant that additional information was necessary to support his claim and afforded him 30 days to submit the necessary information.

In an attending physician's report (Form CA-20) dated August 12, 2015, Dr. Gary Goldstein, a Board-certified orthopedic surgeon, diagnosed internal derangement of the left knee. Although he noted the motor vehicle accident of July 15, 2015, he checked a box indicating that he did not believe appellant's condition was caused or aggravated by the employment activity. Dr. Goldstein did not explain his answer. He listed appellant's period of total disability as August 10 through 21, 2015.

By decision dated August 31, 2015, OWCP denied appellant's claim. It determined that he had not established that the event occurred as described. OWCP further determined that appellant did not submit medical evidence that established a diagnosed medical condition causally related to the alleged event.

Subsequent to the August 31, 2015 decision, appellant submitted new evidence. In a July 28, 2015 report, Dr. Caveng described the automobile accident of July 15, 2015. He noted that appellant's left knee was in severe pain and that he was limping and using pain medication. Dr. Caveng noted prior active problems including lumbar herniated disc, status post lumbar discectomy, hyperlipidemia, chronic low back pain, degenerative joint disease, gastroesophageal reflux disease, and hypertriglyceridemia. He diagnosed internal derangement of left knee joint, lumbar herniated disc, and chronic back pain.

In an August 12, 2015 initial consultation report, Dr. Goldstein noted that appellant had a discectomy on February 10, 2000 at L4-5 and L5-S1. He indicated that in 2006 appellant had complained of stiffness and soreness in the low back and some symptomatology primarily in the left leg. Dr. Goldstein noted that in the interim appellant had been receiving treatment. He noted that appellant was involved in a motor vehicle accident on July 15, 2015 while driving a work vehicle and a car pulled out in front of him and he T-boned that car. Appellant was seen at the emergency room on that date. After examining appellant and reviewing multiple radiographs, Dr. Goldstein diagnosed internal derangement of the left knee precipitated by the July 15, 2015 accident. He noted preexisting hand problems, with the right hand overtly worsened or sustaining a new injury as a result of the July 15, 2015 accident. Dr. Goldstein also noted that appellant had preexisting back problems which either worsened by gait abnormality or by direct trauma or both.

On September 3, 2015 Dr. Goldstein responded to OWCP's questions by indicating that appellant was having left knee and low back pain. He listed his diagnoses of internal derangement of the left knee and lumbar sprain/strain, and indicated that all of the diagnoses were related to the July 15, 2015 motor vehicle accident. In a September 17, 2015 report, Dr. Goldstein indicated that appellant returned with a magnetic resonance imaging (MRI) scan of his left knee, which he determined showed a medial meniscal tear in the context of someone with some, but not extreme arthritis. He noted, however, that prior to the accident appellant had no problem, so he thought the tear was essentially produced or was present in some asymptomatic form due to this accident. Dr. Goldstein explained to appellant that he thought he would ultimately require a knee arthroscopy. He gave appellant a steroid injection into the left knee and initiated physical therapy. Dr. Goldstein opined that appellant could return to work with some accommodation for his knee regarding climbing.

On April 4, 2016 appellant, through counsel, requested reconsideration.

OWCP thereafter received a September 14, 2015 report, wherein Dr. Kristen E. Lott, a Board-certified radiologist, interpreted a left knee MRI scan as showing a complex tear in the posterior root of the medial meniscus with mild extrusion, tricompartmental osteoarthritis with advanced cartilage loss in medial and patellofemoral compartments, and moderate joint effusion.

By decision dated July 26, 2016, OWCP denied modification of its August 31, 2015 decision. It determined that although the evidence of record established that appellant was in a motor vehicle accident on July 15, 2015 during the course of his federal employment, the evidence did not contain a detailed description by a physician explaining how the accident directly caused or aggravated the diagnosed medical conditions.

After this decision, appellant continued to submit evidence. In an October 16, 2015 medical report, Dr. Peter F. DeLuca, a Board-certified orthopedic surgeon, described the automobile accident. He diagnosed pain in appellant's left knee, complex tear of medial meniscus of the left knee as the current injury, and chondromalacia of left knee. Dr. DeLuca also noted a left knee degenerative tear of the medial meniscus, left knee moderate degenerative joint disease, and left knee loose body. He explained to appellant that the automobile accident in July 2015 did not cause his problems. Dr. DeLuca noted that the tear of the meniscus had been there for years and the arthritic changes also had been progressing over the years. He noted that

this may have been exacerbated, but that there was no direct cause. Dr. DeLuca was concerned about appellant's narcotic use. He indicated that appellant would eventually need a knee replacement. On November 3, 2015 Dr. DeLuca performed a left knee arthroscopy and partial medial meniscectomy.

On December 5, 2016 appellant again requested reconsideration.

In a July 16, 2015 x-ray report, Dr. Lori Depersia, a Board-certified radiologist, reviewed an x-ray of appellant's cervical spine and found possible cervical spasm, no acute appearing osseous abnormality identified.

In an April 20, 2016 MRI scan of the lumbar spine, Dr. Edward Podgorski, Jr., a Board-certified radiologist, found bulging disc material with small foraminal herniated disc components at L3-4 and L4-5, bulging disc material with small central herniated disc compartment L5-S1, and no evidence of significant canal stenosis at this time.

In an August 4, 2016 report, Dr. Keith Previs, a Board-certified neurologist, described the automobile accident and related that appellant noted that he started to experience soreness in his neck, lower back, and bilateral knees at the time of the accident. He diagnosed the following conditions causally related to the motor vehicle accident of July 15, 2015: sleep disorder, hypertension, mild cognitive impairment, post-traumatic cervicalgia, clinical cervical radiculopathy, bilateral carpal tunnel syndrome from an electromyography study, post-traumatic lumbago, disc herniation at L4-5 and L5-S1 from MRI scan, clinical lumbar radiculopathy, myofascial pain syndrome, neuropathic pain, and sprains and strains of the left knee. In an August 21, 2016 report, Dr. Previs noted that an electrodiagnostic study was performed on August 16, 2016 that revealed left lumbar radiculopathy at L5 and axonal sensorimotor neuropathy in his bilateral lower extremities.

In a September 6, 2016 report, Dr. Eileen Manabat, a Board-certified anesthesiologist specializing in pain management, noted that as a result of the automobile accident of July 15, 2015, appellant developed an aggravation and exacerbation of preexisting lumbago, lumbar facet syndrome, lumbar radiculopathy at left L5 from electromyogram study, myofascial pain syndrome, muscle spasm, and left knee pain. She instructed appellant to return for treatment.

In a December 5, 2016 report, Dr. Goldstein noted that he reviewed appellant's history of injury and medical treatment. He indicated that appellant had undergone bilateral carpal tunnel surgery in 2006, but had no residuals. Dr. Goldstein noted that the only problem appellant had on an ongoing basis before the employment-related motor vehicle accident was a problem with his low back for which he had been using Tramadol. He noted that appellant's employment duties required that he perform site inspections, which involved climbing in and out of boats. Dr. Goldstein noted that irrespective of whatever residual back issues appellant had previously endured, appellant was functional in a relatively physically active job with no particular complaints regarding the right hand or left knee until the July 15, 2015 employment accident. He noted that appellant's right hand and left knee were identified as problematic areas in the emergency room notes from the date of the accident. Dr. Goldstein opined that appellant sustained a temporal aggravation of his preexisting low back issue, but that it settled down. With regard to the right hand, the 5th finger may have had some preexistent issue. With regard to the

left knee, Dr. Goldstein noted that Dr. Lott talked about tricompartmental changes, which were degenerative. He noted that there was a complex tear of the posterior root of the medial meniscus with extrusion. Dr. Goldstein concluded that irrespective of whatever structural issues there were in the knee, appellant had no problem with the knee before the accident. Appellant could climb in and out of boats and had not received any treatment. Consequently, Dr. Goldstein opined that whatever issues appellant had before the July 15, 2015 employment-related accident were made symptomatic as a result of that accident and that the knee surgery of November 3, 2015 was made necessary as a direct consequence of the July 15, 2015 accident. Dr. Goldstein further opined that the preexisting, but asymptomatic issues in the knee would worsen over time.

By decision dated March 2, 2017, OWCP denied modification of its July 26, 2016 decision. It determined that although the evidence of record established that appellant was in a motor vehicle accident on July 15, 2015 during the course of his federal employment, appellant had not presented a well-reasoned medical opinion on the cause of his diagnosed conditions as they related to the accepted motor vehicle accident of July 15, 2015.

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 time limitation, that an injury was caused in the performance of duty as alleged, and that any disability or specific condition for which compensation is claimed is 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

[3] *Id.*

[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.

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

Appellant filed a claim alleging that, as a result of a July 15, 2015 automobile accident, he injured his right hand and leg, and was subsequently diagnosed with a number of additional medical conditions. OWCP accepted that he was in an employment-related motor vehicle accident on July 15, 2015. However, it denied appellant's claim as the medical evidence of record failed to establish a medical diagnosis causally related to the accepted employment incident.

The Board finds that appellant failed to establish a medical diagnosis causally related to the accepted employment-related motor vehicle accident. Appellant has failed to submit a well-rationalized medical opinion indicating that his medical diagnoses were causally related to the accepted incident.

OWCP received a number of diagnostic studies in support of appellant's claim. The Board finds, however, that the diagnostic studies fail to establish causal relationship. Diagnostic studies are of limited probative value as they do not address whether the July 15, 2015 employment accident caused a diagnosed medical condition.[10] Dr. Elson performed x-rays of appellant's cervical and lumbar spine, right hand and knees on July 16, 2015. On the same date Dr. Despersia also reviewed an x-ray of appellant's cervical spine. Dr. Lott, in a September 14, 2015 report, interpreted the left knee MRI scan. In an April 20, 2016 MRI scan, Dr. Podgorski related findings relative to appellant's lumbar spine. The unsigned discharge instructions from Kennedy Health System are also insufficient to establish appellant's claim. Reports that are unsigned lack proper identification and cannot be considered probative medical evidence if the author is not identified as a physician.[11]

Dr. Caveng noted appellant's employment-related automobile accident of July 15, 2015 in his July 28, 2015 report. He also diagnosed, *inter alia*, derangement of the left knee joint, lumbar herniated disc, and chronic back pain. However, Dr. Caveng reached no conclusion with regard to causation. As his opinion did not address the cause of appellant's diagnosed conditions, his opinion is insufficient to establish causal relationship.[12]

Similarly Dr. Previs, in reports dated August 4 and 21, 2016, described appellant's employment-related motor vehicle accident of July 15, 2015 and determined that the following conditions were causally related to the motor vehicle accident: sleep disorder, hypertension, mild cognitive impairment, post-traumatic cervicalgia, clinical cervical radiculopathy bilateral

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

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

[11] *J.E.*, Docket No. 13-1098 (issued September 3, 2013).

[12] *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

carpal tunnel syndrome, post-traumatic lumbago, disc herniation at L4-5 and L5-S1, clinical lumbar radiculopathy, myofascial syndrome, neuropathic pain, and sprains and strains of the left knee. However, he failed to offer a rationalized medical explanation as to how these conditions were related to the accident.

Dr. Manabat, in a September 6, 2016 report, noted that the automobile accident of July 15, 2015 caused an aggravation and exacerbation of appellant's preexisting lumbago, lumbar facet syndrome, lumbar radiculopathy at L5, myofascial pain syndrome, muscle spasm, and left knee pain. He also did not provide a well-reasoned medical explanation for this conclusion. A mere conclusion without the necessary rationale explaining how and why the physician believes that a claimant's accepted accident could result in a diagnosed condition is not sufficient to meet a claimant's burden of proof.[13]

Dr. DeLuca performed a left knee arthroscopy and partial medial meniscectomy on appellant on November 3, 2015. Previously, in an October 16, 2015 report, he indicated that the July 2015 employment-related accident did not cause appellant's medical problems. Rather, Dr. DeLuca opined that the tear of the meniscus and the arthritic changes had been present for years. Therefore, his report does not support causal relationship.

Dr. Goldstein, in his August 12, 2015 attending physician's report, checked a box indicating that he did not believe that appellant's condition was caused or aggravated by the employment activity, specifically the July 15, 2015 employment-related motor vehicle accident. However, in an initial consultation report of the same date, he indicated that although appellant had numerous preexisting issues, he sustained new injuries and worsening of other injuries as a result of the motor vehicle accident. In a September 3, 2015 report, Dr. Goldstein listed diagnoses of internal derangement of the left knee and lumbar sprain strain and indicated that all of these diagnoses were related to the July 15, 2015 motor vehicle accident. He again noted that although appellant had some preexisting conditions such as a probable tear of the medial meniscus, appellant was asymptomatic prior to this accident, and now due to the accident, required a knee arthroscopy. In a December 5, 2016 report, Dr. Goldstein noted that, prior to the motor vehicle accident, appellant performed a demanding physical job with no particular complaints regarding the right hand or left knee. He believed that the accident resulted in a temporal aggravation of appellant's preexisting low back issue, but that it had settled down. With regard to appellant's right hand, Dr. Goldstein opined that as he had an injury to the lateral fingers and this was a new issue. He again noted that irrespective of whatever structural issues appellant had with his left knee prior to the motor vehicle accident, he could climb in and out of boats and had not received any treatment prior to the accident, and therefore the knee surgery of November 3, 2016 was made necessary as a direct consequence of the July 15, 2015 accident.

Although Dr. Goldstein's reports are generally supportive of causal relationship, he did not provide adequate medical rationale explaining the basis of his opinion on causal relationship. He did not explain the process by which appellant's employment-related motor vehicle accident caused the diagnoses conditions or why these conditions were not due to other factors. A medical opinion should reflect a correct history and offer a medically sound explanation by the

[13] *Supra* note 10.

physician of how the specific employment incident physiologically caused or aggravated the diagnosed conditions.[14] Dr. Goldstein based his opinion in large part on the fact that appellant could perform his duties and was generally asymptomatic prior to the motor vehicle accident and his condition changed after the accident. However, the Board notes that the mere fact that a disease or condition manifests itself or worsens during a period of employment or that work activities produce symptoms revelatory of an underlying condition does not raise an inference of causal relationship between the condition and the employment factors.[15]

An award of compensation may not be based on surmise, conjecture, speculation, or appellant's belief of causal relationship.[16] Appellant has failed to submit rationalized medical evidence to meet his burden of proof on causal relationship.

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 an injury causally related to the accepted July 15, 2015 employment incident.

[14] *See J.M.*, Docket No. 17-1002 (issued August 22, 2017).

[15] *See R.H.*, Docket No. 07-2256 (issued March 3, 2008).

[16] *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 March 2, 2017 is affirmed.

Issued: February 7, 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