United States Department of Labor
Employees' Compensation Appeals Board

M.D., Appellant	)	
and	)	**Docket No. 17-0478**
	)	**Issued: July 5, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Jamaica, NY, Employer	)	

Appearances:
Raymond Bermudez, 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 January 4, 2017 appellant, through her representative, timely appealed from a November 2, 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 the 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 has met her burden of proof to establish a right shoulder condition causally related to the accepted December 16, 2015 employment incident.

FACTUAL HISTORY

On December 19, 2015 appellant, then a 69-year-old mail handler, filed a traumatic injury claim (Form CA-1) alleging that on December 16, 2015 she was picking up a flat tray and felt pain in her right shoulder while in the performance of duty. She explained that she felt pain in her right shoulder through the arm and neck.

In a statement dated December 17, 2015, appellant indicated that, while lifting direct domestic flat trays on December 16, 2015, she felt a slight pain and pulling in her right shoulder. She advised that the pain subsided only to return the next day, on December 17, 2015, at approximately 5:30 a.m. Appellant noted that the pain "gyrated into [her] neck" after lifting the domestic direct trays once again.

OWCP received treatment notes dated December 18, 2015 to February 6, 2016 from Dr. Anthony S. DeSano, a chiropractor. In his December 18, 2015 report and initial evaluation, Dr. DeSano noted that appellant complained of neck pain, which radiated to the right trapezius and to the right posterior forearm, which was described as sharp, stabbing, and tightness. He indicated that appellant's pain was a 10 on a scale of 1 to 10 with 10 being the worst level of pain. Dr. DeSano advised that she indicated that it occurred constantly and started on December 15, 2015 due to severe neck pain radiating into the upper trapezius muscles. He found that palpation of appellant's spine and extremities revealed pain and limited segmental range of motion and subluxation at: C3, C4, C5, C6, C7, T1, T2, and T3, which was confirmed on x-ray of the spine. Dr. DeSano indicated that palpation revealed spasm in the cervical and upper thoracic areas of her spine. He conducted range of motion (ROM) testing and found severe pain with ROM and a normal pin wheel test. Dr. DeSano diagnosed: segmental somatic dysfunction of cervical region; muscle spasm of the neck; cervical disc disorder with radiculopathy of the mid-cervical region; and other cervical disc displacement of the mid-cervical region. He continued to treat appellant and submit reports.

In a development letter dated March 2, 2016, OWCP explained to appellant that her claim initially appeared to be a minor injury that resulted in minimal or no lost time from work. Based on these criteria, the employing establishment did not controvert continuation of pay, or challenge the merits of the claim, and payment of a limited amount of medical expenses was administratively approved. OWCP informed appellant of the type of evidence needed to support her claim and requested that she submit such evidence within 30 days. It also explained that her chiropractor did not qualify as a physician as there was no diagnosis of a subluxation.[3] OWCP explained that, in

[3] OWCP's implementing federal regulations define subluxation to mean an incomplete dislocation, off-centering, misalignment, fixation or abnormal spacing of the vertebrae which must be demonstrated on x-ray. *See* 20 C.F.R. § 10.5(bb).

the absence of a diagnosis of subluxation based on x-rays, he was not considered a physician under FECA.

OWCP received additional treatment notes and duty status reports (Form CA-17) dating from February 17 to April 4, 2016 from Dr. DeSano. Dr. DeSano repeated his previous diagnoses and continued to treat appellant.

In a March 11, 2016 statement, appellant indicated that on the morning of the claimed incident, she was on the flat tray line. She noted that she prepped the mail in the flat trays as they came down the conveyor line. Appellant prepped one tray, it weighing approximately 10 to 15 pounds. She explained that she lifted it up, turned around with a full body turn, and put it on the skid with her knees bent. Appellant indicated that she felt a pulling sensation in her right shoulder, and the pain radiated down her right arm. She advised that she stopped work immediately and informed her supervisor of her injury. Appellant also saw her chiropractor, that day.

By decision dated April 8, 2016, OWCP denied appellant's claim, finding that she failed to establish causal relationship between her diagnosed condition and the accepted employment incident. It found the medical evidence submitted was not supported by objective findings as to how the accepted work incident of December 16, 2015 either indirectly caused or aggravated the diagnosed medical condition of cervical and thoracic subluxation at C3, C4, C4, C6, C7, T1, T2, and T3. OWCP reiterated that chiropractors were only permitted to make a medical diagnosis of a spinal subluxation demonstrated by x-ray. It found that Dr. DeSano failed to provide a well-reasoned medical opinion supported by objective findings.

On April 29, 2016 OWCP received appellant's request for a hearing, which was held before an OWCP hearing representative on September 1, 2016.

A February 11, 2016 magnetic resonance imaging (MRI) scan of the cervical spine, read by Dr. Narayan Paruchuri, a Board-certified diagnostic radiologist, revealed: a broad-based central disc herniation at C4-5, with severe thecal sac impingement and severe lateral recess stenosis and bilateral foraminal impingement; a broad-based disc herniation at C5-6 and thecal sac impingement with impingement upon the cervical cord and severe lateral recess stenosis and bilateral foraminal impingement; left paracentral disc herniation and left foraminal herniation at C6-7; with anterior thecal sac impingement on the left with lateral recess stenosis and left foraminal impingement. Dr. Paruchuri also found right paracentral foraminal herniation at C3-4 and direct impingement upon the right side of the cervical cord with severe right lateral recess stenosis and right foraminal impingement. He further found a disc bulge and bilateral foraminal herniation at C7-T1 and significant left lateral recess stenosis and left foraminal impingement on the right. Dr. Paruchuri's findings also included lateral recess stenosis and right foraminal impingement with anterior thecal sac impingement.

In a March 10, 2016 report, Dr. Mehrdad Golzad, a Board-certified neurologist, noted that appellant was involved in a work-related incident on December 16, 2015. He explained that, on that date, appellant suffered injuries to her neck and right shoulder after lifting a heavy tray. Dr. Golzad indicated that since then she was experiencing persistent pain and discomfort in the neck, right shoulder, and right arm. He noted that her diagnostic studies revealed herniated discs at C4-C5, C5-C6, and C6-C7, a C7-T1 disc bulge and bilateral foraminal herniations. Dr. Golzad

found that her past medical history included: hypertension, diabetes, status post lumbar laminectomy from L2 through S1, severe peripheral vascular disease with femoral and carotid endarterectomy, arterial bypass of the right lower extremity, angioplasty of the right leg and torn meniscus of the right knee. He examined appellant and diagnosed cervical spine disorder and right shoulder disorder. Dr. Golzad requested authorization for additional testing.

In a March 31, 2016 report, Dr. DeSano diagnosed segmental and somatic dysfunction of the cervical region, muscle spasm of the back, and cervical disc disorder with radiculopathy, mid-cervical region. His findings included; intensity, and sharp to dull achy pain and no arm pain. Dr. DeSano recommended a cervical spine MRI scan and continued chiropractic treatment.

In an April 4, 2016 duty status report (Form CA-17) and attending physician's report (Form CA-20), Dr. DeSano diagnosed cervical disc disease with myelopathy and cervical disc disorder. He checked the box marked "yes" in response to whether he believed the condition was caused or aggravated by an employment activity. Dr. DeSano indicated that "repetitive motion led to progressive changes."

In an April 7, 2016 report, Dr. Golzad diagnosed: radiculopathy of the cervical region, other cervical disc displacement, map of the cervical region; intervertebral disc disorders with radiculopathy; lumbosacral region; other intervertebral disc displacement, lumbar region. He advised that appellant could not return to work.

In an April 14, 2016 report, Dr. DeSano explained that he was confused as to how OWCP could say he could only diagnose subluxation and then indicate that he had not provided medical evidence of subluxation. He explained that appellant was injured on the job and initially complained of a shoulder pain. Dr. DeSano examined appellant and found an injury to her neck that was radiating to her arm and shoulder. He explained that he documented subluxation on x-ray and also documented muscle weakness in her right extremity. Dr. DeSano indicated that he clearly listed weak muscles on testing and referenced the right deltoid and triceps "both of which are innervated by nerves in the cervical spine and could cause pain and weakness in the shoulder." He also advised that orthopedic tests were positive, including cervical distraction, foraminal compression, and Soto hall testing. Dr. DeSano opined that all of these indicated a cervical disc disorder that could cause neck, shoulder, and arm complaints. He opined that he believed "that her injury as described to me is the causative factor in [her] complaints." Dr. DeSano explained that he diagnosed subluxation and also correctly diagnosed cervical disc and radiculopathy. He further explained that the CA-17 and CA-20 forms both had small areas for filling in a diagnosis. Dr. DeSano indicated that he placed the most severe diagnosis in the allowable space which is the medical standard. He opined that to "only look at this limited form without looking at the diagnosis as provided on the C4 and C4.2 medical reports as well as my submitted notes is once again 'selectively choosing what part of my records you wish to see' and should be corrected."

In April 20, 2016 report, Dr. DeSano diagnosed segmental dysfunction of cervical region, muscle spasm of back, cervical disc disorder with radiculopathy of the mid-cervical region, and other cervical disc displacement of the mid-cervical region. He explained that his evaluation revealed an underlying right shoulder injury with weakness. Dr. DeSano advised that the neck and right shoulder were affected by the injury. He requested a right shoulder MRI scan and electromyography studies of the right upper extremity to rule out internal derangement and noted

that appellant was disabled and unable to work. Dr. DeSano continued to treat appellant, repeat his opinions and diagnoses in his April 28, June 1, 6, 15, 22, 29, July 13, and August 4, 2016 reports, and indicated that appellant remained disabled.

A May 12, 2016 MRI scan of the right shoulder, read by Dr. Anthony Italiano, a Board-certified diagnostic radiologist, revealed tendinopathy and partial-thickness rotator cuff tear.

In a letter dated May 26, 2016, appellant requested expedited consideration on her hearing date. She enclosed the MRI scan results of her right shoulder and noted that it revealed two tears in her right shoulder "rotary cuff."

In an August 31, 2016 report, Dr. Dante Trovato, a Board-certified orthopedic surgeon, noted that while appellant was performing work typical to her assigned duties as a mail handler, flat tray line/flat prepper, she sustained an injury to her right shoulder and "rotary cuff," which has proven to be debilitating, preventing her from performing her work. He explained that on December 16, 2015, appellant was assigned to perform her usual work of prepping mail in flat trays containing, flats, magazines, *etc*., weighing anywhere between 10 to 40 pounds. Dr. Trovato indicated that her mail was sent to her either on a conveyor belt, in a postal container or on a skid, after she prepped the mail inside the tray, she then placed them either in a postal container or on a skid. He indicated that this was a task that she has performed regularly during 20 years of employment. Dr. Trovato explained that on this occasion, appellant "experienced deep, pulling and lancinating pain which extended from her right shoulder to the right side of her neck and down to her right arm." He advised that she immediately discontinued her work and tried to rest in the hope of relieving the pain. However, appellant had increasing edema and erythema and her supervisor discontinued her workday. Dr. Trovato noted that appellant then took over-the-counter anti-inflammatory medications "to no avail." Furthermore, appellant reported being unable to sleep as her symptoms continued to increase and the next day she went to see her chiropractor. Additionally, Dr. Trovato indicated that she saw a neurologist, after her chiropractor obtained x-rays. He related that the neurologist suggested a right shoulder MRI scan. Dr. Trovato confirmed that it revealed a partial tear in the "rotary cuff" of the right shoulder. He also found that there was no muscle atrophy or muscle edema and no acromial spur or acromial identified. Dr. Trovato opined that these collective findings were consistent with appellant's "report of an acute, pulling injury to the right shoulder occurring under substantial pressure." He explained that the MRI scan testing performed on May 12, 2016, confirmed a partial tear to the soft tissue structure about the right shoulder. Dr. Trovato opined that "[c]onsidering the extent of her injuries and our inability to achieve an appropriate reduction in symptoms using typical treatment methods, cortisone and physical therapy, [appellant], was determined to have a fair prognosis for recovery."

By decision dated November 2, 2016, OWCP's hearing representative affirmed it April 8, 2016 decision. He noted that Dr. Trovato did not mention that the MRI scan also showed tendinopathy, which was suggestive of a preexisting condition of the shoulder prior to the December 16, 2015 employment incident.

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]

Causal relationship is a medical question that generally requires rationalized medical opinion evidence to resolve the issue.[9] A physician's opinion on whether there is causal relationship between the diagnosed condition and the implicated employment factor(s) must be based on a complete factual and medical background.[10] 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).[11]

Certain healthcare providers such as physician assistants, nurse practitioners, physical therapists, and social workers are not considered "physician[s]" as defined under FECA.[12] Consequently, their medical findings and/or opinions will not suffice for purposes of establishing entitlement to FECA benefits.[13]

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[4] *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).

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

[9] *Robert G. Morris*, 48 ECAB 238 (1996).

[10] *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[11] *Id.*

[12] 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t).

[13] *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. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3a(1) (January 2013).

Section 8101(2) of FECA[14] provides that the term physician, as used therein, includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist and subject to regulation by the Secretary.[15] Without a diagnosis of a subluxation from x-ray, a chiropractor is not a physician under FECA and his or her opinion on causal relationship does not constitute competent medical evidence.[16]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish a right shoulder condition causally related to the accepted December 16, 2015 employment incident as the medical evidence of record does not contain a reasoned explanation of how the specific employment incident caused or aggravated appellant's claimed right shoulder conditions.[17] This is especially important as appellant had preexisting conditions and a confirmed history of prior chiropractic treatment as she indicated that she went to see her chiropractor on the date of the incident.

OWCP received a February 11, 2016 MRI scan of the cervical spine, read by Dr. Paruchuri, which revealed a broad-based central disc herniation at C4-5, with severe thecal sac impingement and severe lateral recess stenosis and bilateral foraminal impingement; a broad-based disc herniation at C5-6 and thecal sac impingement with impingement upon the cervical cord and severe lateral recess stenosis and bilateral foraminal impingement; left paracentral disc herniation and left foraminal herniation at C6-7; with anterior thecal sac impingement on the left with lateral recess stenosis and left foraminal impingement. Dr. Paruchuri also found right paracentral foraminal herniation at C3-4 and direct impingement upon the right side of the cervical cord with severe right lateral recess stenosis and right foraminal impingement. He further found a disc bulge and bilateral foraminal herniation at C7-T1 and significant left lateral recess stenosis and left foraminal impingement on the right. Dr. Paruchuri's findings also included lateral recess stenosis and right foraminal impingement with anterior thecal sac impingement. OWCP also received a May 12, 2016 MRI scan of the right shoulder, read by Dr. Italiano, which revealed tendinopathy and partial-thickness rotator cuff tear. The Board notes that these reports merely reported findings and did not contain an opinion regarding the cause of the reported condition. The Board has held that 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.[18] These reports, therefore, are insufficient to establish appellant's claim.

[14] 5 U.S.C. § 8101(2).

[15] *See* 20 C.F.R. § 10.311.

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

[17] *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).

[18] *C.B.*, Docket No. 09-2027 (issued May 12, 2010); *J.F.*, Docket No. 09-1061 (issued November 17, 2009); *A.D.*, 58 ECAB 149 (2006).

OWCP received numerous treatment notes dating from December 18, 2015 to August 4, 2016 from Dr. DeSano, a chiropractor. Section 8101(2) of FECA provides that the term physician includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.[19] In this case, with regard to a diagnosis of subluxation, Dr. DeSano diagnosed several subluxations,[20] including subluxations at: C3, C4, C5, C6, C7, T1, T2, and T3, which was confirmed on x-ray of the spine. Thus, he is a physician as defined under FECA. However, Dr. Sano did not provide a rationalized medical opinion which explained how the lifting of the tray on December 16, 2015 caused all of these subluxations. It is especially important, as the above-noted diagnostic tests reveal several conditions, which appear to be preexisting. Thus, while Dr. DeSano provide multiple reports and explained why the diagnosed conditions were related to the incident, his opinion is of limited probative value as he did not offer a rationalized opinion regarding the subluxations. For example, in his April 14, 2016 report, he questioned why he could not offer a diagnosis other than subluxation. Dr. Sano explained that he diagnosed subluxation and also correctly diagnosed cervical disc and radiculopathy. He further explained that the CA-17 and CA-20 forms both had small areas for filling in a diagnosis. Dr. DeSano indicated that he placed the most severe diagnosis in the allowable space "(Which is the medical standard)." He opined that to "only look at this limited form without looking at the diagnosis as provided on the C4 and C4.2 medical reports as well as many submitted notes is once again 'selectively choosing what part of my records you wish to see' and should be corrected." In this April 20, 2016 report, Dr. DeSano diagnosed segmental dysfunction of cervical region, muscle spasm of back, cervical disc disorder with radiculopathy of the mid-cervical region, and other cervical disc displacement of the mid-cervical region. He explained that his evaluation revealed an underlying right shoulder injury with weakness. Dr. DeSano advised that the neck and right shoulder were affected by the injury. However, his opinion is limited to subluxations and there is no rationale to explain how they are related to the incident.[21]

In a March 10, 2016 report, Dr. Golzad noted that appellant was involved in a work-related accident on December 16, 2015. He explained that on that date, appellant suffered injuries to her neck and right shoulder after lifting a heavy tray. Dr. Golzad reviewed her diagnostic studies, which revealed herniated discs at C4-5, C5-6, C6-7, and C7-T1 disc bulge and bilateral foraminal herniations. He also found that her past medical history included: hypertension, diabetes, status post lumbar laminectomy from L2 through S1; severe peripheral vascular disease with femoral and carotid endarterectomy; arterial bypass of the right lower extremity; angioplasty of the right leg; and torn meniscus of the right knee. Dr. Golzad examined appellant and diagnosed cervical spine disorder and right shoulder disorder. In his April 7, 2016 report, Dr. Golzad diagnosed: radiculopathy of the cervical region, other cervical disc displacement, map of the cervical region; intervertebral disc disorders with radiculopathy; lumbosacral region; and other intervertebral disc displacement, lumbar region. He advised that appellant could not return to work. However,

[19] 5 U.S.C. § 8101(2).

[20] OWCP's implementing federal regulations define subluxation to mean an incomplete dislocation, off-centering, misalignment, fixation or abnormal spacing of the vertebrae which must be demonstrated on x-ray. *See* 20 C.F.R. § 10.5(bb).

[21] *Michelle Salazar*, 54 ECAB 523 (2003).

Dr. Golzad merely provided diagnoses and did not offer any opinion on causal relationship. As the Board has previously noted, 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.[22]

In an August 31, 2016 report, Dr. Trovato indicated that the diagnosed conditions were causally related to the December 16, 2016 incident. He described her mail handler duties and explained that she sustained an injury to her right shoulder and "rotary cuff," which prevented her from performing her work. Dr. Trovato also described what appellant was doing at work on December 16, 2015. He explained that appellant was assigned to perform her usual work of prepping mail in flat trays containing, flats, magazines, *etc*., weighing anywhere between 10 to 40 pounds. Dr. Trovato indicated that her mail was sent to her either on a conveyor belt, in a postal container or on a skid, after she prepped the mail inside the tray, she then placed them either in a postal container or on a skid. He indicated that this was a task that she has performed regularly during 20 years of employment and that on this occasion, appellant "experienced deep, pulling and lancinating pain which extended from her right shoulder to the right side of her neck and down to her right arm." Dr. Trovato confirmed that right shoulder MRI scan revealed a partial tear in the "rotary cuff" of the right shoulder. He opined that these collective findings were consistent with appellant's "report of an acute, pulling injury to the right shoulder occurring under substantial pressure." The Board notes that Dr. Trovato did not note her preexisting conditions and explain how she tore her rotator cuff. In light of her numerous conditions, his conclusion is not sufficiently rationalized. To establish a 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 based on a complete factual and medical background, supporting such a causal relationship.[23] 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. The 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 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.[24] The Board finds that Dr. Trovato's report is of limited probative value.

Because the medical reports submitted by appellant do not address how the December 16, 2015 activities at work caused or aggravated a right shoulder condition, these reports are of limited probative value and are insufficient to establish that the December 16, 2015 employment incident caused or aggravated a specific injury.[25]

On appeal appellant asserts that the claims examiner's opinion was biased and his judgment was clouded based on a previous decision. However, as found above, the medical evidence does

[22] *Supra* note 14; *K.W.*, 59 ECAB 271 (2007).

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

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

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

not explain how the December 16, 2015 activities at work caused or aggravated a right shoulder condition and was insufficient to establish that the December 16, 2015 employment incident caused or aggravated a specific 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 her burden of proof to establish a right shoulder condition causally related to the accepted December 16, 2015 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the November 2, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 5, 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