United States Department of Labor
Employees' Compensation Appeals Board

N.W., Appellant	)	
and	)	**Docket No. 16-1736**
	)	**Issued: March 7, 2018**
DEPARTMENT OF THE TREASURY, INTERNAL REVENUE SERVICE, Evansville, IN, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 30, 2016 appellant, through counsel, filed a timely appeal from a June 20, 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 this case.

ISSUE

The issue is whether appellant met his burden of proof to establish an injury causally related to the accepted April 11, 2013 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 April 11, 2013 appellant, then a 40-year-old senior individual tax advisory specialist, filed a traumatic injury claim (Form CA-1) alleging that on April 11, 2013 he was reaching across a counter while assisting a handicapped taxpayer when he felt a pop in his neck and back. He did not initially stop work.

In a May 8, 2013 report, Dr. Mike W. Chou-Evv, a neurologist, noted that appellant was seen for evaluation following a computerized tomography (CT) scan performed on May 6, 2013. He explained that appellant had a two-level "ACDF" (anterior cervical discectomy and fusion) on January 17, 2013. Dr. Chou-Evv indicated that appellant injured his neck at work on April 11, 2013 and had a current pain level of 10 out of 10 without pain medication. He explained that the CT scan revealed a completely solid fusion between C5-6 and C6-7. Dr. Chou-Evv advised that appellant was status post lateral fusion for pseudoarthrosis in January. He noted that appellant underwent an electromyography (EMG) scan performed by Dr. Eric Weisman, a Board-certified neurologist, who noted that the results were bilateral carpal tunnel syndrome, left C7 cervical radiculopathy, and right radial axonopathy. Dr. Chou-Evv advised that the lower extremity EMG revealed axonal demyelinating polyneuropathy without evidence of lumbar radiculopathy. He explained that appellant had chronic pain issues and opined that the left C7 radiculopathy was "probably neuropathic in origin *i.e.*, not compressive since the last surgery included bilateral foraminotomies for decompression of the nerve root. Also the pain is more of a paraesthetic burning type of pain." Dr. Chou-Evv indicated that appellant's polyneuropathy was "probably diabetic in origin and clearly not a surgical issue."

OWCP received several reports from Dr. Joseph Waling, Board-certified in physical medicine and rehabilitation, dating from June 17, 2013 and continuing. In his June 17, 2013 report, Dr. Waling advised that appellant's chief complaint was left neck and shoulder pain, which extended down to his hips. He indicated the "onset began several years ago with no particular injury or event." Dr. Waling noted that appellant had neck surgery in August 2010 and the second one in January 2012, which was a bilateral C5-7 fusion by Dr. Chou-Evv. He provided diagnoses and noted that appellant underwent a posterior cervical laminectomy and fusion with instrumentation and bone graft on January 17, 2013. In reports dated July 11 and 24, 2013, Dr. Waling diagnosed: postlaminectomy syndrome of the cervical spine; left upper extremity pain D/T (due to) myofascial pain from the cervical into the thoracic spine; S/P (status post) cervical surgery in 2010 and January 2013 per Dr. Chou-Evv; cervical spondylosis without myelopathy with facet-mediated pain; history of pancreatitis; hyperlipidemia; back pain; cervical radiculopathy; neck pain; history of fusion of cervical spine by Dr. Chou-Evv, tachycardia postoperative state; and lumbar back pain and lumbar radicular pain. He noted that appellant had symptoms which included left-sided neck pain that radiated to the left shoulder and back pain in the middle lumbar region, which radiated to the lateral hips, down to the posterior legs equally. Dr. Waling diagnosed cervical radiculopathy, thoracic or lumbosacral neuritis or radiculitis, lumbar back pain, and left shoulder pain.

A January 7, 2013 report from Dr. Andrei Croitoru, Board-certified in internal medicine, revealed a history of chronic pain (cervical, "s/p spinal surgery," local infiltrations, opioid dependent), fibromyalgia, uncontrolled "DM" (diabetes mellitus), and recent episode of acute pancreatitis. In a July 25, 2013 treatment note, Dr. Croitoru indicated that appellant was

admitted for hypertriglyceridemia and acute pancreatitis. Appellant underwent anterior cervical discectomy and fusion followed by a posterior decompression, and epidural steroid injection. He provided notes dated July 26, 2013 and indicated that appellant was discharged.

In a letter dated September 12, 2013, OWCP noted that appellant's claim initially appeared to be a minor injury that resulted in minimal or no lost time from work. Furthermore, it noted that because the employing establishment did not controvert continuation of pay (COP) or challenge the merits of the case, payment of a limited amount of medical expenses was administratively approved. However, appellant's claim was now being reopened because he requested authorization for a surgically-related treatment. OWCP informed him of the type of evidence needed to support his claim and requested that he submit such evidence within 30 days.

In an April 17, 2013 report, Dr. Jeffrey Miller, a Board-certified vascular and interventional radiologist, diagnosed stable anterior and posterior fusion lower cervical spine, mild degenerative disc and posterior spurring and spondylosis posterior aspect of the disc C4-5, with minimal widening anteriorly at the same level.

In an undated attending physician's report (Form CA-20), Dr. Waling checked a box marked "no" with regard to whether there was evidence of preexisting history or disease and diagnosed cervical radiculopathy, back pain, lumbar radicular pain, and history of fusions of the cervical spine. He checked a box marked "no" in response to whether he believed the condition found was caused or aggravated by an employment activity. Dr. Waling noted that the date of his first examination was June 17, 2013 and that appellant was treated on July 11, 24, and 31, 2013. He indicated that appellant was never taken off work.

OWCP received copies of previously submitted reports.

By decision dated November 4, 2013, OWCP denied appellant's claim finding that he did not establish an injury as alleged. It found that the medical evidence was insufficient to establish his claim as there were no medical reports providing sufficient rationale to support causal relationship between the claimed injury and the accepted employment incident. OWCP also explained that Dr. Waling responded "no" in response to whether the condition was caused or aggravated by the alleged work events.

On November 15, 2013 appellant, through counsel, requested a telephonic hearing, which was held before an OWCP hearing representative on May 8, 2014.

By decision dated July, 24, 2014, OWCP's hearing representative affirmed the November 4, 2013 decision.

On October 15, 2014 and February 19, 2015 appellant, through counsel, requested reconsideration and submitted new medical evidence from Dr. Waling.

In July 11, 2013 treatment notes, Dr. Waling diagnosed postlaminectomy syndrome of the cervical spine, left upper extremity pain, "D/T" myofascial pain from the cervical into the thoracic spine, and status post (S/P) cervical surgery times 2010 and January 2013 per

Dr. Chou-Evv. He found back pain, cervical radiculopathy, neck pain, history of cervical fusion of cervical spine, tachycardia postoperative state, lumbar back pain and lumbar radicular pain.

In a July 31, 2013 treatment note, Dr. William M. Roberts, a Board-certified anesthesiologist, found that appellant was status post anterior cervical discectomy and fusion followed by a posterior decompression. He advised that appellant had neck and left shoulder pain that did not respond to cervical medial branch blocks. Dr. Roberts provided a cervical epidural to appellant.

In an August 20, 2013 treatment note, Dr. Waling diagnosed: lumbar spondylosis without myelopathy and facet-mediated pain; lower extremity pain; postlaminectomy syndrome cervical spine; left upper extremity pain "D/T" myofascial pain from the cervical to the thoracic spine, S/P cervical surgery times 2010 and January 2013 per Dr. Chou-Evv, cervical spondylosis without myelopathy with facet-mediated pain; history of pancreatitis, and hyperlipidemia. He referenced back pain, cervical radiculopathy, neck pain, and history of fusion of cervical spine by Dr. Chou-Evv, tachycardia, postoperative state, lumbar back pain and lumbar radicular pain. Dr. Waling provided appellant with a caudal epidural steroid block. He noted that appellant was having difficulty with driving long distances and wished to speak with his supervisor as he needed to work in a closer facility until the bridge into Owensboro, KY was completed.

In an October 23, 2013 treatment note, Dr. Waling noted appellant's history. He repeated his diagnoses. Dr. Waling advised that appellant was having difficulties driving an hour to work due to cervical and lumbosacral pain. He recommended a functional capacity evaluation to determine whether the one-hour driving time was causing the increased spinal pain.

In a letter dated May 12, 2016, counsel for appellant repeated his request for reconsideration and noted that his original request was made on October 10, 2014.

By decision dated June 20, 2016, OWCP denied modification of the prior decision.

LEGAL PRECEDENT

A claimant seeking benefits under FECA[3] 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.[4]

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.[5] The second component is whether the employment incident caused a

[3] *See supra* note 2.

[4] 20 C.F.R. § 10.115(e), (f); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996).

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

personal injury.[6] 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.[7]

Causal relationship is a medical question that generally requires rationalized medical opinion evidence to resolve the issue.[8] 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.[9] 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).[10]

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.[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]

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish that he sustained an injury causally related to the accepted April 11, 2013 employment incident. A treating physician, Dr. Waling, indicated that appellant's condition was not caused or aggravated by his employment activity. Furthermore, the record reveals that appellant had preexisting cervical conditions. In a January 7, 2013 report, Dr. Croitoru reported a history of chronic pain in the cervical area and spinal surgery," opioid dependency, fibromyalgia, uncontrolled "DM,"

[6] *John J. Carlone*, 41 ECAB 354 (1989).

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

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

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

[10] *Id.*

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

[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).

and an episode of acute pancreatitis. The medical evidence contains no reasoned explanation of how the specific employment incident on April 11, 2013 caused or aggravated an injury.[14]

OWCP received several reports from Dr. Waling dating from June 17, 2013 and continuing. In an undated attending physician's report, Dr. Waling checked a box marked "no" with regard to whether there was evidence of preexisting history or disease and diagnosed cervical radiculopathy, back pain, lumbar radicular pain and history of fusions of the cervical spine. At first glance this report appears inaccurate as the record reflects a history of chronic pain in the cervical area and spinal surgery. It is well established that medical reports must be based on a complete and accurate factual and medical background, and medical opinions based on an incomplete or inaccurate history are of little probative value.[15] Dr. Waling also checked a box marked "no" in response to whether he believed the condition found was caused or aggravated by an employment activity. The Board finds that this report does not support that appellant's condition was work related. In his June 17, 2013 report, Dr. Waling advised that appellant's chief complaint was left neck and shoulder pain, which extended down to his hips. He indicated that the "onset began several years ago with no particular injury or event." The Board notes that appellant had several neck conditions which existed prior to the established incident of April 11, 2013. Furthermore, Dr. Waling referenced neck surgery in August 2010 and a second one in January 2012, which was a bilateral C5-C7 fusion performed by Dr. Chou-Evv. He also noted that appellant underwent a posterior cervical laminectomy and fusion with instrumentation and bone graft on January 17, 2013. Other than to support a preexisting condition, this report does not offer any opinion that appellant's condition was work related. Likewise, in reports dated July 11 and 24, 2013, Dr. Waling diagnosed: postlaminectomy syndrome cervical spine; left upper extremity pain D/T myofascial pain from the cervical into the thoracic spine; S/P cervical surgery time 2010 and January 2013 per Dr. Chou-Evv; cervical spondylosis without myelopathy with facet-mediated pain; history of pancreatitis; hyperlipidemia; back pain, cervical radiculopathy; neck pain; history of fusion of cervical spine by Dr. Chou-Evv, tachycardia postoperative state; lumbar back pain and lumbar radicular pain. He noted that appellant had symptoms which included left-sided neck pain that radiated to the left shoulder and back pain in the middle lumbar region, which radiated to the lateral hips, down to the posterior legs equally. Dr. Waling diagnosed cervical radiculopathy, thoracic or lumbosacral neuritis or radiculitis, lumbar back pain, and left shoulder pain. However, he did not attribute any of these conditions to the April 11, 2013 incident. In an August 20, 2013 treatment note, Dr. Waling repeated his diagnoses. He provided appellant with a caudal epidural steroid block. Dr. Waling advised that appellant was having difficulty with driving long distances and wished to speak with his supervisor as he needed to work in a closer facility until the bridge into Owensboro, KY was completed. However, he did not indicate that appellant's conditions were caused or aggravated by the April 11, 2103 incident. As noted above, Dr. Waling responded "no" when asked if they were related to his employment.

Likewise, Dr. Chou-Evv also treated appellant and referred to his preexisting conditions and history of surgery along with diabetes. In his May 8, 2013 report, he explained that he had a

[14] *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).

[15] *Douglas M. McQuaid*, 52 ECAB 382 (2001).

two level "ACDF" on January 17, 2013. Dr. Chou-Evv explained that the CT scan revealed completely solid fusion between C5-6 and C6-7 and determined that appellant was status postero lateral fusion for pseudoarthrosis in January. He also reviewed the EMG scan which revealed bilateral carpal tunnel syndrome, left C7 cervical radiculopathy and right radial axonopathy. Dr. Chou-Evv advised that the lower extremity EMG revealed axonal demyelinating polyneuropathy without evidence of lumbar radiculopathy. He explained that appellant had chronic pain issues and opined that the left C7 radiculopathy was "probably neuropathic in origin *i.e.,* not compressive since the last surgery included bilateral foraminotomies for decompression of the nerve root. Also the pain is more of a paraesthetic burning type of pain." Dr. Chou-Evv opined that appellant's polyneuropathy was "probably diabetic in origin and clearly not a surgical issue." The Board finds that his report is of limited probative value as he attributes the condition to probable diabetes and does not offer any opinion that the condition was caused or aggravated by the April 11, 2013 incident at work.[16]

The record also contains July 31, 2013 treatment note from Dr. Roberts, who found that appellant was status post anterior cervical discectomy and fusion followed by a posterior decompression and provided a cervical epidural to appellant. However, this report is of limited probative value on the relevant issue of the present case in that they do not contain an opinion on causal relationship.

The record contains diagnostic reports to include an April 17, 2013 report from Dr. Miller. However, these reports are insufficient because the physicians did not provide an opinion on the causal relationship of the conditions found on x-rays or diagnostic testing. Therefore, their reports have no probative value in establishing causal relationship.[17]

Because the medical reports submitted by appellant do not address how the April 11, 2013 activities at work caused or aggravated a neck or back condition, these reports are of limited probative value[18] and are insufficient to establish that the April 11, 2013 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 failed to meet his burden of proof to establish an injury causally related to the accepted April 11, 2013 employment incident.

[16] *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).

[17] *See Michael E. Smith*, 50 ECAB 313 (1999).

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

ORDER

IT IS HEREBY ORDERED THAT the June 20, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 7, 2018
Washington, DC

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

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board

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