

**United States Department of Labor
Employees' Compensation Appeals Board**

G.M., Appellant

and

**U.S. POSTAL SERVICE, POST OFFICE,
Indianapolis, IN, Employer**

)
)
)
)
)
)
)
)
)
)
)
)

**Docket No. 16-1764
Issued: March 16, 2018**

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 September 1, 2016 appellant filed a timely appeal from a March 16, 2016 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act¹ (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.²

ISSUE

The issue is whether appellant has met his burden of proof to expand the acceptance of his claim to include additional medical conditions causally related to the employment injury of May 17, 2014.

¹ 5 U.S.C. § 8101 *et seq.*

² Appellant submitted additional evidence with his appeal to the Board. The Board's jurisdiction is limited to the evidence which was before OWCP at the time of its final decision. The Board is, therefore, precluded from considering this additional evidence for the first time on appeal. 20 C.F.R. § 501.2(c)(1); *P.W.* Docket No. 12-1262 (issued December 5, 2012).

FACTUAL HISTORY

On May 20, 2014 appellant, then a 57-year-old mail handler technician, filed a traumatic injury (Form CA-1) claim alleging a sprain to her right shoulder, which occurred on May 17, 2014 in the performance of duty. He completed a second (Form CA-1) on May 20, 2014, explaining that a forklift driver smashed into an all-purpose container (APC), which then slammed into him and knocked him onto the concrete floor. Appellant indicated that he injured his right shoulder, bruised his forearm and lower back, had pain in the legs, mid back, and left knee, and had an accelerated aggravation to a previous back injury. The employing establishment indicated that appellant was injured on the job.

OWCP accepted appellant's claim for right shoulder strain and paid wage-loss compensation and medical benefits.³ It began to receive requests from appellant's medical providers for treatment related to additional conditions that were not initially accepted. They included requests to treat: adhesive capsulitis secondary to trauma to the right dominant shoulder; acromioclavicular arthritis; impingement syndrome; small rotator cuff tear, right shoulder; possible cervical disc disease C3-C7 with injury to the cervical spine at similar setting; and spondylolisthesis at L3-L4 as a result of the accepted May 17, 2014 work injury.

In a November 11, 2014 report, Dr. Allison E. Williams, an attending physician Board-certified in physical medicine and rehabilitation, noted that appellant presented to her office initially on July 29, 2014 following an injury that occurred at work on May 17, 2014. She explained that the injury occurred after a forklift hit an item next to him, which hit appellant in the side of his left arm, pushed him to the floor, and caused him to hit his right shoulder on the floor. Dr. Williams also described his complaints of pain of his left knee, right shoulder, right side of neck, and low back that shot down both legs. She explained that on his initial visit she recommended a magnetic resonance imaging (MRI) scan for his right shoulder and felt he had sacroiliac (SI) joint dysfunction and referred him for physical therapy and started an anti-inflammatory. Dr. Williams advised that on her most recent visit of October 30, 2014, he still had ongoing significant pain in his low back, which was felt to be related to bilateral SI joint dysfunction. She explained that he was referred for bilateral injections and advised to continue his exercise program, along with use of medications Celebrex and Lidoderm. Dr. Williams noted that his lumbar spine films revealed minimal degenerative grade-1 spondylolisthesis at L3-L4 and spondylosis of the lumbar spine.

³ The record reflects that on January 14, 2014 appellant filed a traumatic injury claim advising that on that date he was moving an APC of mail to its proper place when the bar of the APC container right front wheel broke off injuring his lower to middle left back. That claim, OWCP File No. xxxxxx481, was not formally accepted and administratively closed as it appeared to be a minor injury with no lost time. The record reflects that appellant has preexisting conditions to include: "herniorrhaphy"; right knee surgery; left knee surgery; right shoulder surgery; multiple left shoulder surgeries; left elbow surgery; bilateral carpal tunnel surgery; adhesive capsulitis; acromioclavicular arthritis; impingement syndrome; right shoulder rotator cuff tear; and sacroilitis.

By letters dated December 12, 2014, July 22 and August 14, 2015, OWCP informed appellant of the type of evidence needed to support his claim and afforded him 30 days to submit such evidence.⁴

OWCP received several reports from Dr. Williams dated July 29, September 2 and 30, and October 30, 2014. Dr. Williams provided a history of injury and treatment, to include findings upon examination, a diagnosis, and a plan for treatment. The diagnoses included pain in the joint of the upper arm and lower leg and shoulder region, lumbago, and sacroilitis. In her October 30, 2014 report, Dr. Williams related that appellant had decided that “he does not want to return to previous job.”

A September 12, 2014 MRI scan, read by Dr. Sunah C. Kim-Dorantes, a Board-certified diagnostic radiologist, revealed proximal muscle strain, mild tendinopathy of the distal supraspinatus tendons with small sub centimeter full thickness tear of the distal supraspinatus tendon with partial-thickness insertional tear of the posterior supraspinatus to anterior infraspinatus tendons with thin interstitial tear extension into the infraspinatus tendon which was 1.5 centimeters in length and hypertrophic acromioclavicular (AC) joint arthritis.

A September 20, 2014 x-ray, read by Dr. Perry E. Wethington, a Board-certified diagnostic radiologist, revealed no fracture, minimal degenerative grade 1 spondylolisthesis at L3-4, and spondylosis as described.

In a March 3, 2015 report, Dr. Williams noted that she had seen appellant since July 2014 for an accident he sustained while in the course of his normal occupation. She advised that at that time he reported having been hit by an item that was hit by a forklift. Appellant presented with right shoulder pain, left knee pain, and low back pain. The physician determined that low back pain was documented on his initial notes and on the referral. Dr. Williams indicated that appellant was diagnosed with SI joint dysfunction. She noted that the bilateral SI injection was recommended, but was not approved. Dr. Williams explained that she had documented his history as to his injury at work and his subsequent pain. She opined that she believed the conditions were work related. She continued to treat appellant on various dates including June 18 and July 15 and August 13, 2015 and submit reports.

In a March 30, 2015 report, Dr. Janos P. Ertl, a Board-certified orthopedic surgeon, noted appellant’s history of injury and treatment. He examined appellant and provided findings, noting that appellant’s chief complaint was that of a catching sensation and limited abduction. The physician also advised that appellant was unable to reach above the level of the horizontal. Dr. Ertl also found significant pain that impacted his activities of daily living. He diagnosed adhesive capsulitis secondary to trauma to the right dominant shoulder; acromioclavicular arthritis;

⁴ In a letter dated December 8, 2014, appellant informed OWCP that he was having difficulty receiving any type of response from OWCP regarding the care that he was requesting. In a December 24, 2014 memorandum of phone call, OWCP’s claims examiner contacted appellant and explained that additional evidence was needed to support his claim. He was advised that a new letter would be resent which explained the type of evidence to support his claim.

impingement syndrome; small rotator cuff tear, right shoulder; and possible cervical disc disease with injury to the cervical spine at similar setting.

In a July 29, 2015 report, Dr. Ertl noted appellant's history of injury and treatment, provided findings upon examination and diagnosed spontaneous fusion, C3 through C7 anteriorly; possible enthesopathy; degenerative changes, C3 through C7; and recommended rule out recurrent rotator cuff tear, right shoulder. He advised that appellant be referred for a right shoulder MRI scan.

A July 29, 2015 x-ray of the right shoulder, read by Dr. Brian D. White, a Board-certified orthopedic surgeon, revealed some arthritic changes especially in the AC joint, and no definite acute bony injury. A July 29, 2015 cervical spine x-ray read by Dr. Mark Estrada, a Board-certified diagnostic radiologist, revealed multilevel degenerative change and anterior osseous bridging of the cervical spine.

In an August 13, 2015 report, Dr. Ertl provided his history of treatment, the diagnosed conditions, and recommended a plan for treatment. The physician noted that some of the diagnosed conditions which included adhesive capsulitis were secondary to trauma to the right dominant shoulder. Dr. Ertl also noted that appellant had possible cervical disc disease with injury to the cervical spine.

OWCP also received physical therapy reports dating from June 17, 2014 to July 27, 2015.

OWCP continued to develop the claim and by letter dated December 7, 2015, referred appellant for a second opinion with Dr. Norman Mindrebo, a Board-certified orthopedic surgeon, to determine based upon the medical record and physical examination whether the additional diagnoses were causally related to the work injury on May 17, 2014 by causation, acceleration, precipitation or aggravation. Dr. Mindrebo was provided a statement of accepted facts, a set of questions, and a copy of the medical record.

In a January 14, 2016 report, Dr. Mindrebo noted appellant's history of injury and treatment.⁵ He examined appellant and provided findings. The physician explained that appellant had a normal right shoulder examination, and opined that the AC joint arthritis was preexisting. Dr. Mindrebo indicated that the contusion that he sustained on May 17, 2014 in no way continued to aggravate the AC joint arthrosis. He advised that because of his history of a previous rotator cuff tear, it appeared that his right shoulder rotator cuff tear may have been related to his original surgery. The physician noted that appellant had documented underlying cervical disc disease that did not appear to be permanently exacerbated by his fall on the date of injury. Likewise, he advised that the spondylolisthesis at L3-4 was preexisting and had not been permanently aggravated by the fall. Dr. Mindrebo related that appellant had a normal physical examination involving his shoulders and low back and there did not appear to be any active injuries involving his shoulder. He related that there was "certainly" no evidence of adhesive capsulitis. He also determined that appellant did not have any point tenderness at his AC joint and there were no visible signs of

⁵ He also indicated that appellant had retired.

atrophy to suggest a chronic rotator cuff tear. Likewise, Dr. Mindrebo noted there were no strength deficits to rotator cuff testing.

Dr. Mindrebo opined that appellant sustained an initial contusion to his right shoulder because of his history of previous right shoulder surgery and appeared to develop stiffness that was diagnosed as adhesive capsulitis. He found that it responded to physical and occupational therapy and he has undergone unremarkable healing. The physician opined that the preexisting conditions of his shoulder, cervical spine, and lumbar spine appeared to be quiescent and not active at this time and were not permanently aggravated by the fall. Dr. Mindrebo explained that he had answered the questions and provided a complete and thorough diagnosis and examination. He also advised that he had discussed his objective findings and determined that no longer suffers from residuals. The physician explained that despite appellant being retired for over a year, he believed that appellant could return to his work as a mail handler.

By decision dated March 16, 2016, denied appellant's request to expand his claim to include additional medical conditions.

LEGAL PRECEDENT

When an employee claims that he or she sustained an injury in the performance of duty, the employee must submit sufficient evidence to establish that he or she experienced a specific event, incident or exposure occurring at the time and place, and in the manner alleged. The employee must also establish that such event, incident or exposure caused an injury. Once an employee establishes an injury in the performance of duty, he or she has the burden of proof to establish that any subsequent medical condition or disability for work, which the employee claims compensation, is causally related to the accepted injury.⁶ To meet his or her burden of proof, an employee must submit a physician's rationalized medical opinion on the issue of whether the alleged injury was caused by the employment incident.⁷ Medical conclusions unsupported by rationale are of diminished probative value and are insufficient to establish causal relation.⁸

ANALYSIS

OWCP accepted that appellant sustained a sprain of the right shoulder and upper arm, unspecified as a result of the May 17, 2014 work injury. Following the injury, OWCP began receiving requests for treatment of other nonaccepted conditions and what appears to be preexisting conditions as noted above. However, the record does not contain evidence of bridging symptoms between appellant's accepted and diagnosed conditions. Appellant's claimed conditions must be supported by rationalized medical evidence explaining the relationship between the accepted work injury of right shoulder sprain and the additional diagnosed conditions of adhesive capsulitis secondary to trauma to the right dominant shoulder; acromioclavicular arthritis; impingement syndrome; small rotator cuff tear, right

⁶ See *Leon Thomas*, 52 ECAB 202 (2001).

⁷ See *Gary J. Watling*, 52 ECAB 278 (2001).

⁸ *Albert C. Brown*, 52 ECAB 152 (2000).

shoulder; possible cervical disk disease C3-C7 with injury to the cervical spine at similar setting; and spondylolisthesis at L3-L4.

The Board finds that the record establishes that he has numerous preexisting conditions. An opinion that a work-related injury several years prior caused another condition or disability to occur must be based on bridging evidence between the injury and the period of disability or other explanation.⁹ Without supporting medical rationale from a physician, appellant's personal belief that the above listed conditions arose from the accepted work injury of May 17, 2014 is insufficient to establish his claim.¹⁰

In a November 11, 2014 report, Dr. Williams noted that appellant presented to her office initially on July 29, 2014 following an injury that occurred at work on May 17, 2014. She explained that the injury occurred after a forklift hit an item next to him, which hit appellant in the side of his left arm, pushed him to the floor, and caused him to hit his right shoulder on the floor. She also described his complaints of left knee pain from this, right shoulder pain, right-sided neck pain, and low back pain that shot down both legs. The physician explained that on his initial visit, she recommended an MRI scan for his right shoulder and felt he had SI joint dysfunction and referred him for physical therapy and started an anti-inflammatory. Dr. Williams also advised that on her most recent visit of October 30, 2014, he still had ongoing significant pain in his low back, which was felt to be related to bilateral sacroiliac joint dysfunction. However, other than describing the injury that occurred on May 17, 2014, she did not offer any opinion with regard to the above-requested additional conditions. The Board finds that her report is of limited probative value on the relevant issue as it did not contain an opinion on causal relationship.¹¹

In a March 3, 2015 report, Dr. Williams noted that she had seen appellant since July 2014 for an accident he sustained while in the performance of his federal duties. He presented with right shoulder pain, left knee pain, and low back pain. She determined that low back pain was documented on his initial notes and on the referral. Dr. Williams indicated that appellant was diagnosed with (SI) joint dysfunction. She noted that the bilateral SI injection was recommended, but was not approved. Dr. Williams explained that she had documented his history as to his injury at work and his subsequent pain. She opined that the conditions were work related and she continued to treat appellant. However, other than indicating that she believed his conditions were work related, she offered no explanation to explain how the preexisting conditions and additional conditions were causally related to the accepted injury.¹² Without further discussion and rationale, the reports from Dr. Williams are of limited probative value.

⁹ See *Linda L. Mendenhall*, 41 ECAB 532 (1990).

¹⁰ See *Alfredo Rodriguez*, 47 ECAB 437 (1996).

¹¹ 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).

¹² See *supra* note 6.

In a March 30, 2015 report, Dr. Ertl noted appellant's history of injury and treatment. He examined appellant and provided findings. He diagnosed adhesive capsulitis secondary to trauma to the right dominant shoulder; acromioclavicular arthritis; impingement syndrome; small rotator cuff tear, right shoulder; and possible cervical disc disease with injury to the cervical spine at similar setting. However, he did not offer any opinion as to the cause of the additional conditions. Without further discussion and rationale, the report from Dr. Ertl is of limited probative value. Likewise, in his August 13, 2015 report, Dr. Ertl noted that some of the diagnosed conditions which, included adhesive capsulitis, were secondary to trauma to the dominant right shoulder. However, he did not indicate which ones or explain how he arrived at this conclusion. The physician also noted that appellant had possible cervical disc disease with injury to the cervical spine. The Board has held that an opinion which is speculative in nature has limited probative value in determining the issue of causal relationship.¹³

The record also contains diagnostic reports including a September 12, 2014 MRI scan, read by Dr. Kim-Dorantes; a September 20, 2014 x-ray read by Dr. Wethington; a July 29, 2015 x-ray of the right shoulder read by Dr. White; and a July 29, 2015 cervical spine x-ray read by Dr. Estrada, which revealed multilevel degenerative change and anterior osseous bridging of the cervical spine. However, these reports are insufficient to establish appellant's claim because none of the physicians provided an opinion on the causal relationship of the conditions found on diagnostic testing and the accepted work injury. Therefore, their reports have no probative value in establishing causal relationship.¹⁴

OWCP also received physical therapy reports dating from June 17, 2014 to July 27, 2015. However, physical therapists are not considered physicians as defined under FECA and thus their reports do not constitute competent medical evidence.¹⁵ Consequently, these reports are insufficient to establish expansion of appellant's claim.

The Board also notes that in a January 14, 2016 report, the second opinion physician, Dr. Mindrebo, determined that the additional diagnoses offered by the treating physicians were preexisting conditions and were not permanently aggravated by the May 17, 2014 work injury. Furthermore, he determined that appellant no longer suffered from residuals of his work injury.

The Board finds that appellant has not met his burden of proof because the medical opinion evidence in this case is insufficient to establish the critical element of causal relationship between appellant's diagnosed conditions and the accepted work injury.

On appeal, appellant argues that he satisfied the necessary elements to meet his burden of proof as the medical evidence of record was sufficiently rationalized. However, as found above, the medical evidence was insufficient to meet his burden of proof to establish the expansion of his claim to include additional diagnoses.

¹³ *Arthur P. Vliet*, 31 ECAB 366 (1979).

¹⁴ *See Michael E. Smith*, 50 ECAB 313 (1999).

¹⁵ *Id.*; *J.M.*, 58 ECAB 448 (2007); *G.G.*, 58 ECAB 389 (2007); *David P. Sawchuck*, 57 ECAB 316 (2006); *Allen C. Hundley*, 53 ECAB 551 (2002).

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 expand the acceptance of his claim to include additional medical conditions causally related to the employment injury of May 17, 2014.

ORDER

IT IS HEREBY ORDERED THAT the March 16, 2016 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 16, 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