

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

C.D., Appellant)	
)	
and)	Docket No. 17-1357
)	Issued: May 4, 2018
U.S. POSTAL SERVICE, POST OFFICE,)	
Bellmawr, NJ, Employer)	
)	

Appearances:
Michael D. Overman, Esq., for the appellant¹
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
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On June 9, 2017 appellant, through counsel, filed a timely appeal from an April 10, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act² (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 her burden of proof to establish left shoulder rotator cuff syndrome and shoulder impingement, herniated nucleus pulposus (HNP) bulge of the cervical

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.*

intervertebral disc, and HNP bulge of the lumbar intervertebral disc causally related to the accepted February 23, 2015 employment injury.

FACTUAL HISTORY

On February 23, 2015 appellant, then a 63-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that, on February 23, 2015, she sustained injuries to her back, right elbow, and head as a result of slipping and falling in an icy parking lot at work. The claim form did not indicate whether she stopped work. By decision dated July 9, 2015, OWCP accepted appellant's claim for right elbow and back contusions, lumbar sprain, and neck sprain.

Dr. Allen Nau, an emergency medicine physician, initially treated appellant at the emergency room. In February 23, 2015 hospital records, he related that she slipped and fell on ice while walking from the parking lot to a building at work and hit the back of her head. Upon physical examination of appellant's neck, Dr. Nau noted paravertebral tenderness and normal range of motion. Examination of appellant's lumbar spine showed full range of motion and mild tenderness over the lumbar spine and sacrum. Dr. Nau indicated that examination of her right upper extremity revealed swelling, tenderness, and ecchymosis to the right elbow and no tenderness with full range of motion of the right shoulder, wrist, and hand. He noted diagnoses of superficial head injury and contusion of the back and elbow.

Appellant also underwent a series of diagnostic examinations. In a February 23, 2015 lumbar and cervical spine x-ray examination report, Dr. Stanley Rich, a Board-certified diagnostic radiologist, reported diffuse demineralization of the osseous structures and no evidence of acute fracture in her lumbar spine. He also indicated a negative examination of the cervical spine. In a February 23, 2015 brain computerized tomography scan report, Dr. Howard Rosenstein, a Board-certified diagnostic radiologist, noted normal scan of the brain. In a February 23, 2015 right elbow x-ray examination report, Dr. Peter Kouveliotis, a Board-certified diagnostic radiologist, related normal radiographs of the right elbow.

In a February 27, 2015 report, Dr. Nasser Ani, a Board-certified orthopedic surgeon, indicated that appellant was examined for complaints of pain in the neck, bilateral shoulders, low back, and right elbow following a slip and fall at work on February 23, 2015. He reported diagnoses of pain in joint shoulder, rotator cuff syndrome, shoulder impingement, elbow contusion, neck sprain, lumbar sprain, HNP bulge of the cervical intervertebral disc, and HNP bulge of the lumbar intervertebral disc. Dr. Ani related that appellant should remain off work for two weeks. He provided a duty status report (Form CA-17), which indicated that she could return to work with restrictions on March 13, 2015.

In a March 4, 2015 left shoulder magnetic resonance imaging (MRI) scan report, Dr. Timothy Howard, a Board-certified diagnostic radiologist, noted rotator cuff tendinosis and sub deltoid bursitis, mild degenerative changes, partial thickness bursal surface fraying, and low grade rotator cuff tear.

Dr. Ani continued to treat appellant. In March 13 and May 1, 2015 reports, he related her complaints of mild-to-moderate neck and back pain and limited mobility with overhead lifting and reaching. Dr. Ani reviewed appellant's history and conducted an examination. He reported

restricted range of motion of the cervical spine. Examination of appellant's lumbar spine revealed tenderness in the paraspinal muscles and restricted range of motion with flexion and extension. Dr. Ani reported mild pain with internal rotation of her bilateral shoulders and positive impingement sign. He also noted tenderness in appellant's right elbow. Dr. Ani diagnosed bilateral shoulder pain, bilateral rotator cuff syndrome, left shoulder tendinopathy with partial tear, bilateral shoulder impingement, elbow contusion, neck sprain, lumbar sprain, HNP bulge of the cervical intervertebral disc, and HNP bulge of the lumbar intervertebral disc. He indicated in duty status reports that appellant could work modified duty.

In an April 2, 2015 lumbar spine MRI scan report, Dr. Payam Torrei, a Board-certified diagnostic and neuroradiologist, noted mild lumbar spondylosis and small central disc protrusion at L5-S1. In a cervical spine MRI scan report, he observed several small cervical disc protrusions without spinal stenosis or cord compression.

Appellant also underwent an April 15, 2015 right shoulder MRI scan by Dr. Salim Banbahji, a Board-certified diagnostic radiologist. He reported a near complete full-thickness tear of the supraspinatus tendon, infraspinatus and subscapularis tendinopathy without discrete high-grade tears, marked biceps long head tendinopathy with longitudinal tearing/cystic degeneration, subacromial subdeltoid bursitis, and small soft tissue contusion in the posterior shoulder.

In a May 27, 2015 report, Dr. Ani described appellant's complaints of pain and conducted an examination. He diagnosed joint shoulder pain, rotator cuff syndrome, shoulder impingement, elbow contusion, HNP bulge of the cervical intervertebral disc, and HNP bulge of the lumbar intervertebral disc. Dr. Ani provided out of work note and duty status reports, which indicated that appellant could work modified duty.

Counsel related in a letter dated June 11, 2015 that appellant was initially treated in the emergency room on February 23, 2015 for complaints of significant pain in her neck and for a concussion. He requested that her claim be accepted for low back, right elbow, bilateral shoulder, head, and neck injuries. Counsel explained that he was in the process of obtaining medical support for appellant's traumatic injury claim.

OWCP also received appellant's supplemental explanation of her claim. Appellant described the February 23, 2015 employment incident and explained that she initially experienced cervical and lumbar pain. She indicated that the shoulder injury was not immediately evident because during her hospital visit, she was not asked to move her arm in different directions. Appellant related that she did not realize she had significant shoulder pain until she returned home.

In a June 18, 2015 report, Dr. Ani indicated that appellant had been under his care since February 27, 2015 for an injury to her right shoulder, neck, and right elbow after a slip and fall on ice while working. He reported that examination of her right shoulder showed weakness of the rotator cuff with 4/5 positive impingement. Dr. Ani explained that a May 1, 2015 right shoulder MRI scan showed a near complete full thickness tear of the supraspinatus tendon with bursitis and tendinopathy and a left shoulder MRI scan revealed tendinopathy with partial tear. He diagnosed right shoulder rotator cuff tear and tendinopathy. Dr. Ani opined that appellant's right shoulder injury was directly related to the accident at work. He recommended surgery.

While OWCP accepted appellant's claim on July 9, 2015 for right elbow and back contusion, lumbar and neck sprain, in a separate July 9, 2015 decision, OWCP denied her claim for the conditions of bilateral rotator cuff syndrome, bilateral shoulder impingement, right shoulder rotator cuff tear and tendinopathy, HNP bulge of the cervical intervertebral disc, and HNP bulge of the lumbar intervertebral disc. It found that the medical evidence of record was insufficient to establish that these medical conditions were causally related to the February 23, 2015 employment incident.

By letter dated July 20, 2015, counsel requested that appellant's accepted conditions be expanded to include the right shoulder condition and that authorization for right shoulder surgery be granted as outlined in Dr. Ani's June 18, 2015 report.

On July 22, 2015 OWCP received appellant's request, through counsel, for a hearing.

Appellant submitted a June 29, 2015 electromyography and nerve conduction velocity (EMG/NCV) studies by Dr. Steve M. Aydin, Board-certified in pain medicine and physical medicine and rehabilitation. Dr. Aydin reported electrodiagnostic evidence of a mild carpal tunnel syndrome in the bilateral upper extremities. He noted no evidence of cervical radiculopathy in the bilateral upper extremities and no evidence of a large fiber peripheral neuropathy in the bilateral upper extremities.

Dr. Ani continued to treat appellant. In reports dated July 1 to September 17, 2015, he reviewed her history and provided examination findings similar to his previous examinations. Dr. Ani related that a June 29, 2015 EMG/NCV study showed mild carpal tunnel syndrome in the bilateral upper extremities. He diagnosed joint shoulder pain, bilateral rotator cuff syndrome, left shoulder tendinopathy with partial tear, bilateral shoulder impingement, elbow contusion, HNP and bulge of the cervical intervertebral disc, HNP and bulge of the lumbar intervertebral disc, and bilateral carpal tunnel syndrome. Dr. Ani indicated that appellant could continue working modified duty. He recommended surgery to repair her rotator cuff tear.

In a July 31, 2015 letter, Dr. Ani related that he had treated appellant since a February 23, 2015 employment injury. He related that examination of her right and left shoulder revealed moderate limitation of range of motion with positive impingement signs and weakness of the rotator cuff. Dr. Ani listed various diagnostic examinations which showed right shoulder tendinopathy and supraspinatus tear, left shoulder tendinopathy with partial tear, cervical spine small disc protrusions, lumbar spine multiple degenerative disc disease with herniation, and bilateral carpal tunnel syndrome. He opined that the "above diagnoses are directly related to the accident on February 23, 2015." Dr. Ani recommended surgery on both shoulders and pain management for the cervical spine.

A hearing was held on November 6, 2015 before an OWCP hearing representative. Appellant explained that she sought treatment at the emergency room and then from Dr. Ani. She indicated that she had four MRI scans of both shoulders, neck, and lower back and described their findings. Counsel alleged that Dr. Ani's July 31, 2015 report clearly described the February 23, 2015 employment incident and mechanism of injury of how appellant's bilateral shoulder, cervical, and lumbar conditions resulted from the slip and fall incident at work.

In a November 17, 2015 letter, Dr. Ani noted that appellant had been under his care since February 27, 2015. He explained that she had an injury to her shoulder, neck, and right elbow after a slip and fall at work. Dr. Ani reported that physical examination of appellant's right shoulder showed weakness of the rotator cuff with 4/5 positive impingement and described the MRI examination scans of her bilateral shoulders. He diagnosed right shoulder rotator cuff tear and tendinopathy with partial tear. Dr. Ani opined that appellant's "slip and fall on ice while working which occurred on February 23, 2015 is a direct cause of [appellant's] rotator cuff tear of the right shoulder. When [she] fell on the ice she put out her arm in an outstretched manner to catch herself from further injury. This mechanism of injury is the direct cause of the rotator cuff tear." He emphasized the importance for her to undergo surgery.

By decision dated January 21, 2016, an OWCP hearing representative affirmed OWCP's July 9, 2015 decision in part and set aside and remanded in part. He found that the medical evidence of record was insufficient to establish that appellant sustained bilateral rotator cuff syndrome, bilateral shoulder impingement, right rotator cuff tear and tendinopathy, HNP/bulge cervical intervertebral disc, and HNP/bulge lumbar intervertebral disc as a result of the February 23, 2015 employment injury. The hearing representative also determined however that the medical evidence submitted to the record post-hearing was sufficient to establish a diagnosis of right shoulder rotator cuff tear and tendinitis. He remanded the prior OWCP decision for development of the record to determine whether appellant's right shoulder condition was causally related to the accepted February 23, 2015 employment injury.

OWCP referred appellant's claim, along with a statement of accepted facts (SOAF) and a copy of the record, to Dr. Stanley Askin, a Board-certified orthopedic surgeon and second opinion examiner, to determine whether her right shoulder condition was causally related to the accepted February 23, 2015 employment incident and whether she sustained any additional diagnosed conditions as a result of the accepted February 23, 2015 employment incident. In a March 4, 2016 report, Dr. Askin reviewed the SOAF and accurately described the February 23, 2015 employment incident. He related appellant's complaints of worsening right shoulder pain, worse with lifting, and pain in the right trapezial area. Appellant indicated that she continued to work and was able to accommodate her route due to her right shoulder complaints. Upon physical examination of her neck, Dr. Askin reported full range of motion in flexion, extension, and rotation to either side with complaints of discomfort when she looked toward the right. He related that examination of appellant's left shoulder showed stiffness and audible palpable clicking. Dr. Askin indicated that right shoulder range of motion revealed pain at 160 degrees forward flexion and 110 degrees of abduction. Neer/Hawkins test was negative. Dr. Askin reported that Phalen's and Tinel's signs were positive bilaterally, which was suggestive of subclinical carpal tunnel syndrome. He noted appellant's accepted conditions of right elbow contusion and lumbar sprain. Dr. Askin indicated that Dr. Ani provided additional diagnoses of bilateral rotator cuff syndrome, bilateral shoulder impingement, HNP/bulge cervical intervertebral disc, HNP/bulge lumbar intervertebral disc, and right shoulder rotator cuff tear and tendinopathy.

Dr. Askin opined that the objective examination findings of appellant's shoulders were "manifestations of underlying degenerative changes within the shoulder due to attrition of the rotator cuff described as 'tear' on the right and tendinosis on the left." He noted that with respect to her right shoulder it was "possible" that underlying degenerative changes could be provoked by a traumatic event. Dr. Askin related however that what was missing was a "nexus between the

described slip and fall and the right shoulder imperfections identified on MRI [scan].” He explained that the shoulder MRI scan imperfections, including the right rotator cuff tear, bilateral rotator cuff syndrome, and bilateral shoulder impingement, were common accompaniments of aging and understood to be able appropriate degenerative changes. Dr. Askin noted that nothing identified on appellant’s MRI scan studies was specifically traumatically induced. He concluded that her right shoulder injury was not causally related to the accepted February 23, 2015 incident and also not medically necessary to treat appellant’s February 23, 2015 employment injury. Dr. Askin further opined that the medical evidence did not support additional conditions due to the accepted February 23, 2015 employment trauma.

By decision dated December 9, 2016, OWCP denied appellant’s claim for additional conditions based on the March 4, 2016 report of Dr. Askin, the second opinion examiner. It found that the medical evidence of record did not support that appellant sustained bilateral rotator cuff syndrome, bilateral shoulder impingement, right rotator cuff tear and tendinopathy, HNP/bulge cervical intervertebral disc, and HNP/bulge lumbar intervertebral disc causally related to the accepted February 23, 2015 employment incident.

On December 20, 2016 appellant, through counsel, requested a hearing before an OWCP hearing representative, which was held on March 1, 2017. Counsel asserted that Dr. Askin’s March 4, 2016 second opinion report was not sufficiently well rationalized because Dr. Askin merely provided a general response to its questions and did not provide any medical rationale to support his conclusion that she did not sustain any additional conditions as a result of the accepted February 23, 2015 employment incident. He also asserted that a conflict in medical evidence existed between Dr. Askin, OWCP’s second opinion examiner, and Dr. Ani, appellant’s treating physician, regarding whether appellant sustained additional bilateral shoulder, cervical, and lumbar conditions as a result of the accepted February 23, 2015 employment incident, thereby warranting referral to an impartial medical examiner.

By decision dated April 10, 2017, an OWCP hearing representative affirmed the December 9, 2016 decision in part and vacated the decision in part. He found that the medical evidence of record was insufficient to establish that appellant’s left shoulder, neck, and back conditions were causally related to her February 23, 2015 employment injury. The hearing representative determined that there was sufficient medical evidence regarding whether appellant sustained a right shoulder injury causally related to her February 23, 2015 employment injury and remanded the case for further development of the medical evidence.

LEGAL PRECEDENT

Where an employee claims that a condition not accepted or approved by OWCP was due to an employment injury, he or she bears the burden of proof to establish that the condition is causally related to the employment injury.³ To establish causal relationship between the condition as well as any attendant disability claimed and the employment injury, an employee must submit rationalized medical evidence based on a complete medical and factual background supporting

³ *Jaja K. Asaramo*, 55 ECAB 200 (2004).

such causal relationship.⁴ Causal relationship is a medical issue and the medical evidence generally required to establish causal relationship is rationalized medical opinion evidence.⁵ 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.⁶ Neither the fact that a disease or condition manifests itself during a period of employment, nor the belief that the disease or condition was caused or aggravated by employment factors or incidents, is sufficient to establish causal relationship.⁷

Section 8123(a) of FECA provides that if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.⁸ This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.⁹

ANALYSIS

Initially OWCP accepted appellant's claim for right elbow and back contusions, and lumbar and neck sprain due to a slip and fall incident that occurred in the performance of duty on February 23, 2015. In the most recent merit decision dated April 10, 2017, an OWCP hearing representative remanded the case for further development of the medical evidence as to whether her right shoulder conditions were causally related to the accepted February 23, 2015 employment injury.¹⁰ However, in the decision dated April 10, 2017, the hearing representative affirmed OWCP's prior decision finding that the medical evidence of record was insufficient to establish that appellant's left shoulder rotator cuff syndrome and shoulder impingement, HNP bulge of the cervical intervertebral disc, and HNP bulge of the lumbar intervertebral disc were causally related to her February 23, 2015 employment injury.

The Board finds that appellant has not met her burden of proof to establish additional left shoulder, cervical, and lumbar conditions causally related to her accepted injury.

⁴ *M.W.*, 57 ECAB 710 (2006); *John D. Jackson*, 55 ECAB 465 (2004).

⁵ *I.R.*, Docket No. 09-1229 (issued February 24, 2010); *D.I.*, 59 ECAB 158 (2007).

⁶ *I.J.*, 59 ECAB 408 (2008); *Victor J. Woodhams*, 41 ECAB 465 (2005).

⁷ *Jennifer Atkerson*, 55 ECAB 317 (2004).

⁸ 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

⁹ 20 C.F.R. § 10.321.

¹⁰ Because OWCP has not issued a final decision on the issue of expansion of the claim to include a right shoulder injury, that matter is in an interlocutory posture as OWCP has remanded the matter for further development. *See* 20 C.F.R. § 501.2(c). *See also G.L.*, Docket No. 07-1450 (issued January 29, 2008).

Appellant initially submitted a report from Dr. Nau, who treated her at the emergency room on February 23, 2015. Dr. Nau however offered no opinion as to whether the conditions in questions were causally related to the accepted employment incident. 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.¹¹ Causal relationship is a medical question that must be established by probative medical opinion from a physician.¹²

OWCP also received a number of diagnostic reports. The Board has held that reports of diagnostic tests, are of limited probative value as they fail to provide an opinion on the causal relationship between appellant's employment duties and the diagnosed conditions.¹³ For this reason, this evidence is not sufficient to meet her burden of proof.¹⁴

Appellant submitted various reports from Dr. Ani dated February 27 to November 17, 2015. Dr. Ani provided examination findings and diagnosed among other conditions, left rotator cuff syndrome, left shoulder tenopathy with partial tear, left shoulder impingement, elbow contusion, neck sprain, lumbar sprain, HNP bulge of the cervical intervertebral disc, and HNP bulge of the lumbar intervertebral disc. In a July 31, 2015 letter, he opined that the above diagnoses were directly related to the February 23, 2015 work accident. The Board has long held that a mere conclusion, without the necessary medical rationale explaining how and why the physician believes that a claimant's accepted exposure could result in a diagnosed condition, is insufficient to meet the claimant's burden of proof.¹⁵ Dr. Ani offered no rationalized medical explanation as to how physiologically appellant's accepted fall on February 23, 2015 would have caused these various diagnosed conditions. Without explaining how physiologically the movements involved in the employment incident caused or contributed to the diagnosed conditions, Dr. Ani's opinion is of limited probative value.¹⁶

In a March 4, 2016 report, Dr. Askin, an OWCP second opinion examiner, disagreed with Dr. Ani's medical opinion. He provided an accurate history of appellant's injury and conducted a physical examination. Dr. Askin related that her left shoulder condition was tendinitis, which based upon objective findings was a manifestation of underlying degenerative changes. He concluded that the medical evidence did not support any additional conditions due to the accepted February 23, 2015 employment trauma. Dr. Askin provided a medical explanation supported by objective findings. His opinion was based on an accurate background. The Board finds that

¹¹ See *S.G.*, Docket No. 17-1054 (issued September 14, 2017).

¹² *W.W.*, Docket No. 09-1619 (issued June 2, 2010); *David Apgar*, 57 ECAB 137 (2005).

¹³ *Supra* note 11.

¹⁴ See *A.B.*, Docket No. 17-0301 (issued May 19, 2017).

¹⁵ See *A.B.*, Docket No. 16-0864 (issued November 16, 2016).

¹⁶ See *T.H.*, Docket No. 17-0833 (issued September 7, 2017).

Dr. Askin's second opinion is of probative medical value and represents the weight of the medical evidence.¹⁷

Because appellant has not submitted medical evidence establishing that the conditions of left shoulder rotator cuff syndrome and shoulder impingement, HNP bulge of the cervical intervertebral disc, and HNP bulge of the lumbar intervertebral disc were causally related to her February 23, 2015 employment injury, she has not met her burden of proof.

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 left shoulder rotator cuff syndrome and shoulder impingement, HNP bulge of the cervical intervertebral disc, and HNP bulge of the lumbar intervertebral disc causally related to the accepted February 23, 2015 employment injury.

ORDER

IT IS HEREBY ORDERED THAT the April 10, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 4, 2018
Washington, DC

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

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

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

¹⁷ See *G.H.*, Docket No. 16-0876 (issued May 2, 2017).