United States Department of Labor
Employees' Compensation Appeals Board

D.A., Appellant	)	
and	)	**Docket No. 18-0525**
	)	**Issued: November 2, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
ALEC J. KOROMILAS, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 18, 2018 appellant, through counsel, filed a timely appeal from an August 8, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has established that appellant's diagnosed cervical radiculopathy, cervical facet syndrome, cervical and lumbar radiculopathy, bilateral carpal tunnel

[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.*

syndrome, and bilateral wrist tenosynovitis are causally related to the accepted January 2, 2017 employment injury.

FACTUAL HISTORY

On January 3, 2017 appellant, then a 60-year-old bulk mail technician, filed a traumatic injury claim (Form CA-1) alleging that, while at work on January 2, 2017, a chair rolled out from under her, causing her to fall directly onto a cement floor, landing on her right side. She alleged that this caused pain in her back, left chin, right leg extending to her hip, neck, and right arm. Appellant also alleged subsequent sporadic headaches. She stopped work on January 3, 2017.

In a January 4, 2017 report, Dr. Deborah K. Witt, a family medicine practitioner, noted that x-rays of appellant's cervical spine, lumbar spine, and right pelvis were performed. She diagnosed neck muscle spasm, acute bilateral low back pain without sciatica, acute post-traumatic headache, acute right hip pain, and pain in joint of right shoulder. On January 6, 2017 Dr. Witt noted appellant's complaints of significant low back, right hip, and right shoulder pain after a fall and advised that she could not work.

By development letter dated January 23, 2017, OWCP informed appellant of the deficiencies of her claim and advised her of the type of medical and factual evidence needed to establish the claim. It afforded her 30 days to submit the necessary evidence

In a February 10, 2017 letter, Dr. Witt described appellant's history of injury and noted that she had been seen on five occasions. She described x-ray findings and indicated that appellant had noted point tenderness at the hip with decreased hip and low back range of motion, and mild swelling with right buttock numbness. Dr. Witt noted ultimate diagnoses of lumbar radiculopathy due to degenerative joint disease, aggravated by her fall. She advised that appellant could not work.

By decision dated March 2, 2017, OWCP found that the January 2, 2017 incident occurred as alleged, but denied the claim, finding that appellant had not submitted medical evidence containing a medical diagnosis caused by the accepted employment incident.

On March 17, 2017 appellant, through counsel, requested a hearing before an OWCP hearing representative.

Additional medical evidence was submitted including a January 4, 2017 x-ray of appellant's cervical spine that demonstrated disc space narrowing, most severe at C5-6 and C6-7, multilevel anterior osteophytes in the lower cervical spine, and mild foraminal narrowing at C4-5 bilaterally. Lumbar spine x-ray that day demonstrated degenerative disc space narrowing at S1-2 and facet arthropathy at L5-S1. Hip x-ray showed no fracture or degenerative joint disease of the hip joints.

In a January 10, 2017 report, Dr. Jeremy David Close, Board-certified in family medicine, noted examination findings of cervical spine soreness and mild right buttock pain on straight leg raising. He reviewed the January 4, 2014 x-rays and indicated that they showed cervical and lumbar degenerative changes. Dr. Close diagnosed radiculopathy of the cervical region and acute right-sided low back pain without sciatica.

Dr. Witt completed a duty status report (Form CA-17) on February 7, 2017, noting findings of decreased right hip and lumbar range of motion with radicular symptoms, and other disabling conditions of obesity and arthritis. She advised that appellant could not return to work.

An April 4, 2017 magnetic resonance imaging (MRI) scan of appellant's cervical spine demonstrated cervical spondylosis, most significant at C6-7.

By report dated April 18, 2017, Dr. Steven J. Valentino, a Board-certified osteopath specializing in orthopedic surgery, noted symptoms of radiating neck pain which appellant related to the accepted January 2, 2017 employment incident. Cervical spine examination demonstrated significantly limited range of motion in all planes with spasm, facet synovitis, and effusion, radiating arm pain with Spurling's maneuver, and 4/5 weakness of the upper extremities with decreased sensation. Lumbar spine examination demonstrated marked spasm, and straight leg raising test reproduced low back and buttock pain. Appellant's examination was otherwise normal. Dr. Valentino diagnosed cervical (neck) pain, sprain of ligaments of cervical spine and lumbar spines, and cervical radiculitis. He indicated that appellant's ongoing symptoms and diagnoses were related to her work injury by direct cause and by aggravation and recommended further testing.

An upper extremity electromyogram/nerve conduction velocity (EMG/NCV) study on May 1, 2017 demonstrated severe right and mild-to-moderate left carpal tunnel syndrome.

In a June 15, 2017 report, Dr. Scott M. Fried, a Board-certified osteopath specializing in orthopedic surgery, described job duties appellant had performed for over 30 years at the employing establishment. He noted her description of injury where she landed hard on her right hand, hitting her shoulder, and entire right side on January 2, 2017. Dr. Fried described current complaints of ongoing severe pain and discomfort with numbness and tingling in the right hand and wrist, radiating neck and paracervical pain, and low back and right hip pain, with some left upper extremity symptoms of intermittent numbness and tingling. He reviewed appellant's x-rays, MRI scan, EMG/NCV test, and Dr. Valentino's report. Dr. Fried described cervical spine findings of decreased range of motion, tenderness, muscle spasm, and noted that Tinel's testing of the median nerve at the wrist was positive bilaterally. Tinel's and compression testing of the right radial nerve at the elbow was positive, and Tinel's was positive at the infraclavicular and supraclavicular fossae of the right thoracic outlet. Phalen's test was positive in the right hand, and compression testing was positive in the wrist bilaterally. Synovitis was noted at the volar and carpal tunnel in both wrists consistent with flexor tenosynovitis. Roos and Hunter's tests were positive on the right, and motor function of the right long thoracic nerve was decreased with tenderness to palpation. Dr. Fried diagnosed right median and radial neuropathy, left median neuropathy, right brachial plexopathy/cervical radiculopathy, scapular winging with long thoracic neuritis, cervical strain and sprain with right radiculopathy and aggravation of cervical disc disease, disc space narrowing at multiple levels with radiculopathy, and right shoulder rotator cuff strain and sprain. He opined that there was "no doubt" that appellant had a significant injury on June 2, 2017, with a side-bending whiplash injury that aggravated her cervical disc disease, a traction injury to the nerve roots of C5 through T1 with evidence of long thoracic nerve stretch, and traumatic injury to the radial and median nerves in the right upper extremity with double crush syndrome. Dr. Fried recommended additional testing, a functional capacity evaluation, pain management, and therapy.

During the hearing, held on July 12, 2017, appellant testified that, on January 2, 2017, she fell onto her buttocks on a cement floor and then tilted to the right, involving her entire right side. She indicated that she finished the two hours remaining on her shift, but became very sore and went to see Dr. Witt on January 4, 2017, who took her off work. Appellant stated that she was not under medical treatment prior to the January 2017 incident and had not returned to work. Counsel argued that, as all conditions diagnosed by Dr. Fried and Dr. Valentino were causally related to the accepted January 2, 2017 employment incident, the claim should be accepted for all diagnosed conditions.

In a May 9, 2017 report, Dr. Valentino reiterated appellant's physical findings. He advised that the January 2, 2017 employment incident caused cervical and lumbar strain and sprain, aggravation of cervical and lumbar degenerative disc disease, facet syndrome with cervical and lumbar radiculitis, and cervical radiculopathy. Dr. Valentino maintained that when appellant fell backwards onto her buttocks she hyperextended her cervical and lumbar spine, as confirmed by physical examination. He advised that she could not return to work.

An upper extremity EMG/NCV study completed on August 2, 2017 demonstrated severe right median nerve impairment at the wrist level, mild left median nerve impairment at the wrist level, moderate right posterior interosseous nerve impairment at the radial tunnel level, normal on the left, and mild right ulnar nerve impairment at the elbow level, normal on the left.

In a treatment note dated August 8, 2017, Dr. Fried described appellant's ongoing complaints of bilateral upper extremity and neck pain. He described physical examination findings and advised that she remained significantly symptomatic and could not work.[3]

By decision dated August 18, 2017, an OWCP hearing representative modified the March 2, 2017 decision, finding that appellant had established cervical and lumbar sprains and a right shoulder sprain resulting from the January 2, 2017 employment injury. He further found, however, that the medical evidence of record was insufficient to establish that additional conditions of cervical radiculopathy, cervical facet syndrome, cervical and lumbar radiculopathy, bilateral carpal tunnel syndrome, and bilateral wrist tenosynovitis were caused by her fall at work on January 2, 2017.

LEGAL PRECEDENT

An employee has the burden of proof to establish that any specific condition for which compensation is claimed is causally related to the employment injury.[4] Causal relationship is a medical issue, and the medical evidence required to establish a causal relationship is rationalized medical evidence.[5] 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

[3] Dr. Fried had previously advised that appellant had been fitted with a custom splint to address her documented injuries.

[4] *Kenneth R. Love*, 50 ECAB 276 (1999).

[5] *Jacqueline M. Nixon-Steward*, 52 ECAB 140 (2000).

the specific employment factors identified by the employee.[6] Neither the mere 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]

It is well established that where employment factors cause an aggravation of an underlying physical condition, the employee is entitled to compensation for periods of disability related to the aggravation. Where the medical evidence supports an aggravation or acceleration of an underlying condition precipitated by working conditions or injuries, such disability is compensable. However, the normal progression of untreated disease cannot be said to constitute "aggravation" of a condition merely because the performance of normal work duties reveal the underlying condition. For the conditions of employment to bring about an aggravation of preexisting disease, the employment must cause acceleration of the disease or precipitate disability.[8]

ANALYSIS

The Board finds that appellant has not established that the cervical radiculopathy, cervical facet syndrome, cervical and lumbar radiculopathy, bilateral carpal tunnel syndrome, and bilateral wrist tenosynovitis are causally related to the accepted January 2, 2017 employment injury.

Appellant submitted a January 10, 2017 report from Dr. Close who noted x-ray findings of cervical and lumbar degenerative changes and diagnosed radiculopathy of the cervical region and low right-sided low back pain without sciatica. Dr. Close, however, offered no opinion as to whether his diagnosed conditions were causally related to the accepted employment incident of January 2, 2017. Medical evidence that does not offer any opinion regarding the cause of an employee's condition is of no probative value on the issue of causal relationship.[9]

Dr. Witt provided reports dated January 4 to February 10, 2017. On February 10, 2017 she indicated that the ultimate diagnosis was lumbar radiculopathy due to degenerative joint disease, aggravated by fall. 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.[10] Dr. Witt offered no rationalized medical explanation as to how, appellant's accepted fall on January 2, 2017 would have caused her diagnosed condition. Without explaining how, physiologically, the movements involved in the employment incident caused or contributed to aggravated lumbar degenerative joint disease, Dr. Witt's opinion is of limited probative value.[11]

[6] *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

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

[8] *A.C.*, Docket No. 08-1453 (issued November 18, 2008).

[9] *L.B.*, Docket No. 18-0533 (issued August 27, 2018); *D.K.*, Docket No. 17-1549 (issued July 6, 2018).

[10] *See A.B.*, Docket No. 16-0864 (issued November 16, 2016); *Beverly A. Spencer*, 55 ECAB 501 (2004).

[11] *C.D.*, Docket No. 17-1357 (issued May 4, 2018).

In an April 18, 2017 report, Dr. Valentino noted symptoms of radiating neck pain which appellant related to the accepted January 2, 2017 employment injury. He described findings on examination and diagnosed cervical (neck) pain, sprain of ligaments of cervical and lumbar areas of the spine, and cervical radiculitis. Dr. Valentino indicated that appellant's ongoing symptoms and diagnoses were related to her work injury by direct cause and aggravation and recommended further testing. He later advised on May 9, 2017 that, when appellant fell backwards onto her buttocks, she hyperextended her cervical and lumbar spine, as confirmed by physical examination. Appellant, however, indicated on the claim form that she landed on her right side when a chair rolled out from under her. Although she testified during the July 12, 2017 hearing that she first landed on her buttocks and then tilted to the right, the Board has held that contemporaneous evidence is entitled to greater probative value than later evidence.[12] Dr. Fried also commented that appellant landed on her right side. Thus, Dr. Valentino's opinion is also of limited probative value as he based his opinion on a correct history and mechanism of injury.[13] It is therefore insufficient to meet appellant's burden of proof to establish that her diagnosed conditions were caused by the accepted January 2, 2017 employment injury.[14]

Dr. Fried submitted reports dated June 15 and August 8, 2017. In his initial report he described appellant's job duties and that she indicated that she landed hard on her right hand, hitting her shoulder, and entire right side on January 2, 2017. Dr. Fried described complaints involving the right hand and wrist, neck and paracervical area, low back, right hip, and left upper extremity. He reviewed diagnostic studies and Dr. Valentino's report. Dr. Fried described physical examination findings and diagnosed right median and radial neuropathy, left median neuropathy, right brachial plexopathy/cervical radiculopathy, scapular winging with long thoracic neuritis, cervical strain and sprain with right radiculopathy and aggravation of cervical disc disease, disc space narrowing at multiple levels with radiculopathy, and right shoulder rotator cuff strain and sprain. He opined that there was "no doubt" that appellant had a significant injury on June 2, 2017, with a side-bending whiplash injury that aggravated cervical disc disease, a traction injury to the nerve roots of C5 through T1 with evidence of long thoracic nerve stretch, and traumatic injury to the radial and median nerves in the right upper extremity with double crush syndrome. In a treatment note dated August 8, 2017, Dr. Fried described appellant's ongoing complaints of bilateral upper extremity and neck pain. He described physical examination findings and advised that appellant remained significantly symptomatic and could not work. The Board finds that Dr. Fried also did not provide sufficient rationale. He did not describe the specific mechanics of the diagnosed side-bending whiplash injury, or his other diagnosed conditions. Without further explanation of how physiologically the January 2, 2014 fall caused or contributed to the diagnosed condition, Dr. Fried's opinion is of limited probative value.[15]

[12] *See S.S.*, 59 ECAB 315 (2008).

[13] *See C.K.*, Docket No. 17-1853 (issued August 27, 2018).

[14] *Id.*; *see supra* note 4.

[15] *See supra* note 13.

Appellant also submitted diagnostic studies in support of her claim. Diagnostic studies are of limited probative value as they do not address whether the employment injury caused any diagnosed conditions.[16]

On appeal counsel argues that the medical reports of Dr. Valentino and Dr. Fried establish that the additional conditions should be accepted or, at the very least, further development of the medical evidence by OWCP is warranted. In the instant case, the record lacks rationalized medical evidence establishing causal relationship between the January 2, 2017 employment injury and the additional diagnoses rendered by Dr. Valentino and Dr. Fried. Thus, appellant has not met her burden of proof.[17]

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 established that her diagnosed cervical radiculopathy, cervical facet syndrome, cervical and lumbar radiculopathy, bilateral carpal tunnel syndrome, and bilateral wrist tenosynovitis are causally related to the accepted January 2, 2017 employment injury.

[16] *See supra* note 9.

[17] *See J.S.*, Docket No. 18-0249 (issued August 27, 2018).

ORDER

IT IS HEREBY ORDERED THAT the August 8, 2017 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 2, 2018
Washington, DC

Patricia H. Fitzgerald, Deputy 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