United States Department of Labor
Employees' Compensation Appeals Board

D.C., Appellant	)	
and	)	**Docket No. 18-1425**
	)	**Issued: March 15, 2019**
U.S. POSTAL SERVICE, POST OFFICE, Port Arthur, TX, Employer	)	

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 July 17, 2018 appellant filed a timely appeal from March 26 and May 23, 2018 merit decisions of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (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 her burden of proof to establish a back condition causally related to the accepted factors of her federal employment.

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the May 23, 2018 decision, OWCP received additional evidence. However, section 501.2(c)(1) of the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this evidence for the first time on appeal. *Id.*

FACTUAL HISTORY

On January 23, 2017 appellant, then a 56-year-old rural carrier, filed an occupational disease claim (Form CA-2) alleging that she sustained a back injury as a result of her federal employment duties. She heard a pop in the middle of her back when she reached for a handful of mail. Appellant indicated that she first became aware of her condition on January 29, 2016 and realized its relationship to her federal employment on February 20, 2016. She stopped work on January 29, 2016. No additional evidence was submitted.

OWCP, by development letter dated January 31, 2017, advised appellant of the factual and medical deficiencies of her claim. It provided a questionnaire for her completion regarding the circumstances of the injury. Appellant was also asked to provide a narrative medical report from her physician which contained a detailed description of findings and diagnoses, explaining how the claimed work activities caused, contributed to, or aggravated her medical condition. In a separate letter dated January 31, 2017, OWCP also requested that the employing establishment provide additional information in response to her allegations. It afforded both parties 30 days to submit the requested information.

In an undated letter, appellant related that she had worked at the employing establishment for over 22 years. She again claimed that she sustained an injury on January 29, 2016. Appellant indicated that within two to three weeks later she went from limping and dragging her leg to using a cane and then to using a wheelchair. She described her current emotional condition and noted that she had undergone surgeries.

In an undated narrative statement, appellant related that she had put small and heavy trays of mail and parcels into the back of the jeep and while on her route she turned to the left to get mail out of a tray and felt pain in both legs which started to stiffen. She reiterated that she heard and felt a loud pop in her back.

Appellant submitted a progress note dated March 3, 2016 from Rhonda Reed, a nurse practitioner. Ms. Reed related a history that appellant began to experience lower back pain in December 2015 and that her pain progressively worsened. She provided an assessment of other hereditary and idiopathic neuropathies, radiculopathy of the lumbar region, peripheral neuropathy of (or chronic neurogenic changes of) the bilateral lower extremities, affecting the sensory and motor components of the nerves predominantly affecting the axoris, subacute to chronic L2-S1 radiculopathy on the right and left and muscle spasms in the lumbar paraspinal muscles that may be masking the acute radiculopathy changes.

An April 4, 2016 computerized tomography (CT) scan of the abdomen and pelvis read by Dr. Stephen N. Cherewaty, a diagnostic radiology specialist. As to appellant's spine he noted mild degenerative changes in the lumbar spine.

On April 5, 2016 Dr. Gregory C. Diaz, Board-certified in diagnostic radiology, read magnetic resonance imaging (MRI) scans of the cervical, thoracic, and lumbar spines. He reported that the cervical spine MRI scan revealed multilevel central stenosis and spondylosis, compressive disc herniations at C5-6 and C6-7, largest at C5-6, and no abnormal enhancement of the cord. Dr. Diaz indicated that the thoracic spine MRI scan revealed marked central stenosis and cord

flattening with abnormal cord enhancement at the T6-7 level and markedly compressive left paracentral disc herniation, and multilevel spondylosis, disc bulging, and mild central stenosis. He related that the lumbar spine MRI scan demonstrated stable spondylotic changes and central stenosis from L3-4 through L5-S1, most severe at L4-5 with an "AP" canal diameter approximately four millimeters.

In a tissue consultation report dated April 6, 2016, Dr. Jason Matherne, Board-certified in anatomic and clinical pathology, noted a preoperative diagnosis of thoracic disc herniation, T5-10 with spinal cord compression, and lower extremity weakness. He provided a final diagnosis of intervertebral discs, C6 and C7, discectomies, fragments of disrupted and degenerated fibrocartilage, and negative for malignancy.

In an intraoperative neurophysiology report dated April 6, 2016, Dr. Sujin Yu, a Board-certified neurologist, noted a diagnosis of thoracic stenosis and performed a thoracic laminectomy at T5-10.

By letter dated February 13, 2017, the employing establishment controverted appellant's claim. It noted that the March 3, 2016 report revealed that she had experienced pain beginning in December 2015 and contended that this was unrelated to the alleged date of injury of January 29, 2016. The employing establishment further contended that appellant failed to explain what caused her claimed injury. It indicated that she submitted a duplicate claim for a February 8, 2016 traumatic injury, which had been denied. The employing establishment requested that OWCP deny appellant's claim because she had not established causal relationship or fact of injury.

On February 21, 2017 appellant responded to OWCP's development questionnaire. She related that as a rural carrier she cased mail and took mail down from a case. Appellant also picked up heavy packages and placed them in her jeep and delivered them. She engaged in repetitive twisting and turning to retrieve mail from her tray, 5 to 6 days a week, 15 to 17 years.

Appellant submitted a December 8, 2015 report in which Dr. Brent Jacobson, Board-certified in diagnostic radiology, read an x-ray of her lumbar spine. Dr. Jacobson provided an impression of no acute lumbar abnormality and moderate degenerative arthrosis.

Appellant also submitted progress notes dated January 15 and February 4, 2016 from Ms. Reed. She reiterated her assessment of other hereditary and idiopathic neuropathies and radiculopathy of the lumbar region. Ms. Reed also provided an assessment of other intervertebral disc degeneration, lumbosacral region, spinal stenosis, and degenerative spondylolisthesis at L4-5, multilevel osteophytes, multilevel degenerative facet arthropathy, and mild disc space narrowing at L4-5 and S1.

In a report dated January 28, 2016, Dr. Tawfeeq Sayyed, Board-certified in diagnostic radiology and nuclear medicine, read a lumbar spine MRI scan. He provided an impression of moderate-to-severe degenerative changes in the mid-lumbar spine resulting in severe canal stenosis at L4-5, moderate canal stenosis at L3-4 and L5-S1, and mild canal stenosis at L2-3.

Dr. Yu, in a January 28, 2016 report, indicated that an electrodiagnostic study revealed peripheral neuropathy of (or chronic neurogenic changes of) the bilateral lower extremities, affecting the sensory and motor components of the nerves predominantly affecting the axons,

subacute to chronic L2-S1 radiculopathy on the right and left, and muscle spasms in the lumbar paraspinal muscles that may be masking the acute radiculopathy changes. On February 2, 2016 she reported that she was performing an electromyogram of appellant's bilateral lower extremities due to back pain that radiated down to her left thigh with numbness. Dr. Yu noted appellant's chief complaints of left hip pain and numbness/tingling in the left thigh. She related a history that, on Thanksgiving at appellant's mother's house, appellant was mopping the floor when she experienced pain on the left side of her back. A couple of days later appellant's pain worsened while she was helping her daughter move. She reported to Dr. Yu that the numbness in her left thigh began about three weeks prior and she had to drag her foot when she walked. On December 8, 2015 appellant sought medical treatment at an emergency center where an x-ray of her lumbar spine was performed and she received pain medication. Dr. Yu provided an assessment of other hereditary and idiopathic neuropathies and radiculopathy, lumbar region.

A report dated February 10, 2016 from appellant's physical therapist addressed appellant's back and lower extremity conditions and physical limitations.

In progress notes dated March 22, September 6 and 20, and October 10, 2016, Dr. David Singleton, a pain medicine specialist, reported appellant's chief complaint of a lumbar epidural steroid injection at left L3-5 and bilateral L3-S1 facet. He noted her history of hypertension and medications.

In progress notes dated July 19, 2016 through February 14, 2017, Dr. Erwin Lo, a Board-certified neurosurgeon, reported appellant's history and findings on physical examination. He provided an assessment of spinal stenosis of the thoracic and lumbar regions, status post thoracic laminectomy performed three months ago for disc herniation causion spinal cord compression, slow improvement with physical therapy, transient improvement after bilateral facet blocks at right L3-S1 radio frequency ablation, more neurogenic claudication, right leg weaker than left leg, and bilateral severe sacroiliitis.

A report dated September 19, 2016 from Dr. Mustafa I. Musa, a Board-certified internist, noted appellant's diagnoses, medications, and referrals for medical care and laboratory work.

On December 29, 2016 Dr. Josefine Timm, Board-certified in diagnostic radiology and neuroradiology, examined a lumbar spine MRI scan. She found intervertebral disc degeneration and bulging and degenerative facet and ligamentum flavum hypertrophy from L3-4 to L5-S1, mild degenerative subluxation at L3-4 and L4-5, marked relative compression of the thecal sac at L4-5 and L3-4 and to a moderate degree at L2-3, complete effacement of cerebrospinal fluid (CSF) in the bilateral subarticular lateral recesses, more extensive on the left at L4-5, compression of the thecal sac in the subarticular lateral recess on the left at L5-S1, and more prominent right lateral bulging was seen at L4-5 with mild posterior displacement of the L4 nerve root sleeve lateral to the neural foramen on the right. Dr. Timm also read a thoracic MRI scan. She provided an impression of intervertebral disc degeneration and bulging from T5-6 through T8-9 with moderate to marked mass effect on the anterior thecal sac at these levels, posterior decompression had been performed at T6-7. Dr. Timm further provided an impression of focal cystic encephalomalacia in the spinal cord at T6-7, facet and ligamentum flavum hypertrophy causes mass effect on the thecal sac posteriorly at T4-5 and T5-6 and primarily on the right at T9-10 and on the left at T10-11. Minimal posterior element hypertrophy was seen at T7-8 and T8-9. However, prominent posterior

bulging and relatively prominent posterior epidural fat were seen with attenuation of CSF around the spinal cord and complete effacement of CSF and posterior to the cord at T7-8. Slight cord compression was suspected at this level. Dr. Timm related that higher resolution imaging with high field strength magnet or myelogram CT scan would better define the margins of the spinal cord at this level, if indicated.

By decision dated March 21, 2017, OWCP denied appellant's occupational disease claim finding that the medical evidence of record was insufficient to establish that she had an injury and/or medical condition causally related to accepted employment factors.

On May 23, 2017 appellant requested reconsideration. She resubmitted Dr. Lo's February 14, 2017 progress note.

By decision dated August 21, 2017, OWCP denied modification of its March 21, 2017 decision finding that the medical evidence submitted was insufficient to establish causal relationship between appellant's diagnosed back condition and the accepted factors of her federal employment.

OWCP subsequently received progress notes dated January 8 and 25, and February 8, 2018 by Dr. Jerry M. Keepers, an anesthesiologist. The progress notes related appellant's work duties and medical, social, and family history, and examination findings. Dr. Keepers diagnosed displacement of thoracic and lumbar intervertebral discs, chronic pain syndrome, chronic postsurgical pain, thoracic and lumbar radiculopathy, thoracic spine pain, thoracic or lumbosacral neuritis or radiculitis, unspecified, and backache.

On March 21, 2018 appellant requested reconsideration of OWCP's August 21, 2017 decision and submitted additional factual evidence. She provided a narrative statement dated January 8, 2018 in which she again described her rural carrier duties.

By decision dated March 26, 2018, OWCP denied modification of its March 21, 2018 decision, finding that Dr. Keepers had failed to provide a rationalized opinion explaining how the diagnosed conditions were caused or aggravated by the accepted factors of appellant's federal employment.

Appellant requested reconsideration on May 8, 2018. She submitted a January 8, 2018 letter from Dr. Keepers. Dr. Keepers again related appellant's rural carrier duties. He noted that an MRI scan revealed evidence of a compromise of the thoracic spinal canal at multiple levels. There was also a severe compromise of the spinal canal in the lumbar region at L3-4, L4-5, and L5-S1. Dr. Keepers indicated that appellant had thoracic surgery several months later and lumber surgery over a year later, but she continued to have significant thoracic and low back pain. He maintained that, at this point, she had failed surgical syndrome of the thoracic and lumbar areas. Appellant also developed chronic pain syndrome. Dr. Keepers noted that she reported her pain as 10 out of 10 on a visual analogue scale. He opined that appellant sustained an injury in the performance of her duties as a rural mail carrier. Dr. Keepers maintained that her diagnosis of a thoracic/lumbar injury was due to repetitive pushing/pulling of equipment, bending, stooping, lifting, and reaching above her shoulders.

OWCP subsequently received progress/procedure notes dated March 19, April 16, and May 16, 2018 from Dr. Keepers. Dr. Keepers again examined appellant and reiterated his prior diagnoses. He also diagnosed neuritis and/or radiculitis due to displacement of lumbar intervertebral disc. Dr. Keepers again noted his opinion that appellant's diagnosed conditions were work related.

By decision dated May 23, 2018, OWCP denied modification of its March 26, 2018 decision. It again found that Dr. Keepers had failed to provide a rationalized opinion on causal relationship between appellant's diagnosed conditions and accepted factors of her federal employment.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim, including the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was timely filed within the applicable time limitation period of FECA,[3] that an injury was sustained in the performance of duty as alleged and that any disability or medical condition for which compensation is claimed is causally related to the employment injury.[4] These are the essential elements of each and every compensation claim, regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[5]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed;[6] (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition;[7] and (3) medical evidence establishing that the employment factors identified by the claimant were the proximate cause of the condition for which compensation is claimed or, stated differently, medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant.[8]

The medical evidence required to establish causal relationship is rationalized medical opinion evidence. The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable certainty, and must be supported by

[3] *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *J.P.*, 59 ECAB 178 (2007); *Joe D. Cameron*, 41 ECAB 153 (1989).

[4] *J.M.*, Docket No. 17-0284 (issued February 7, 2018); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[5] *K.M.*, Docket No. 15-1660 (issued September 16, 2016); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

[6] *Michael R. Shaffer*, 55 ECAB 386 (2004).

[7] *Marlon Vera*, 54 ECAB 834 (2003); *Roger Williams*, 52 ECAB 468 (2001).

[8] *Beverly A. Spencer*, 55 ECAB 501 (2004).

medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[9]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish a back condition causally related to the accepted factors of her federal employment.

OWCP accepted as factual that appellant engaged in repetitive activities in her employment duties as a rural carrier. The issue, therefore, is whether appellant submitted sufficient medical evidence to establish that the accepted employment exposure caused or aggravated a back condition.

Dr. Keepers' January 8, 2018 report and March 19, April 16, and May 16, 2018 progress/procedure notes related a description of appellant's accepted repetitive rural carrier duties and discussed examination findings. He diagnosed displacement of thoracic and lumbar intervertebral discs, chronic pain syndrome, chronic postsurgical pain, thoracic and lumbar radiculopathy, thoracic spine pain, thoracic or lumbosacral neuritis or radiculitis, unspecified, backache, and neuritis and/or radiculitis due to displacement of lumbar intervertebral disc. Dr. Keepers opined that appellant's diagnosed conditions were caused by her repetitive work duties. Although he provided an opinion on causal relationship, the Board finds that he did not provide medical rationale to support his opinion. The Board has found that a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale.[10] Dr. Keepers did not explain how the accepted employment factors caused or aggravated appellant's diagnosed thoracic and lumbar conditions. The Board finds that the lack of medical rationale diminishes the probative value of Dr. Keepers' opinion.[11] Other reports by him did not offer a medical opinion addressing whether the diagnosed thoracic and lumbar conditions were caused or aggravated by the established employment factors. Medical evidence that does not offer an opinion regarding the cause of an employee's condition is of no probative value on the issue of causal relationship.[12]

Likewise, Dr. Yu's reports dated February 2 and April 6, 2016 and Dr. Lo's progress notes dated July 19, 2016 through February 14, 2017 also fail to contain an opinion on the cause of appellant's diagnosed lumbar and thoracic conditions. The Board finds, therefore, that these reports and progress notes are insufficient to establish her claim.[13]

[9] *See J.R.*, Docket No. 17-1781 (issued January 16, 2018); *I.J.*, 59 ECAB 408 (2008).

[10] *See S.M.*, Docket No. 16-1312 (issued December 7, 2016); *S.E.*, Docket No. 08-2214 (issued May 6, 2009); *T.M.*, Docket No. 08-0075 (issued February 6, 2009).

[11] *See* S.*M.*, *id.*; *Deborah L. Beatty*, 54 ECAB 340 (2003) (where the Board found that, in the absence of a medical report providing a diagnosed condition and a reasoned opinion on causal relationship with the employment incident, appellant did not meet her burden of proof).

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

[13] *Id.*

The reports dated December 8, 2015 through December 29, 2016 by Drs. Cherewaty, Diaz, Matherne, Jacobson, Sayyed, Yu, and Timm interpreted diagnostic findings and the laboratory report dated February 10, 2016 revealed blood test results. The Board has held that reports of diagnostic tests lack probative value as they do not provide an opinion on causal relationship between appellant's employment duties and a diagnosed condition.[14]

The various reports dated March 22 through October 10, 2016 by Dr. Singleton and Dr. Musa addressed appellant's medical history, including receiving a lumbar epidural steroid injection, but failed to provide a firm diagnosis of a particular medical condition, history of injury, or offer an opinion as to whether the accepted employment factors caused or aggravated her conditions.[15]

The progress notes and report from Ms. Reed, a nurse practitioner, and appellant's physical therapist have no probative medical value. Neither nurse practitioners nor physical therapists are considered physicians as defined under FECA and, therefore, these opinions are insufficient to establish the claim.[16]

As appellant has not submitted rationalized medical evidence to support her claim that her back condition was caused by factors of her federal employment, 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 a back condition causally related to the accepted factors of her federal employment.

[14] *See L.M.*, Docket No. 18-0473 (issued October 22, 2018); *R.T.*, Docket No. 17-2019 (issued August 24, 2018).

[15] *See supra* note 12.

[16] *See David P. Sawchuk*, 57 ECAB 316, 320 n. 11 (2006) (lay individuals such as physician assistants, nurses, and physical therapists are not competent to render a medical opinion under FECA); 5 U.S.C. § 8101(2) (this subsection defines a physician as surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by state law). *S.S.*, Docket No. 18-0950 (issued October 23, 2018) (physical therapists are not considered physicians under FECA); *S.J.*, Docket No. 17-0783, n.2 (issued April 9, 2018) (nurse practitioners are not considered physicians under FECA); *Charley V.B. Harley*, 2 ECAB 208, 211 (1949) (a medical issue such as causal relationship can only be resolved through the submission of probative medical evidence from a physician).

ORDER

IT IS HEREBY ORDERED THAT the May 23 and March 26, 2018 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: March 15, 2019
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