

ISSUE

The issue is whether appellant met his burden of proof to establish that his right shoulder and neck conditions are causally related to the February 1, 2018 accepted employment incident.

FACTUAL HISTORY

On February 24, 2018 appellant, then a 57-year-old nursing assistant, filed a traumatic injury claim (Form CA-1) alleging that on February 1, 2018 he injured his neck and shoulder while in the performance of duty. He explained that, after providing care to a resident, he stood up and hit his head on the resident's tripod and jammed his neck, causing pain in his neck and shoulder. On the reverse side of the claim form the employing establishment indicated that appellant was injured in the performance of duty.

February 21, 2018 progress notes by Dr. Bruce Eagleson, a Board-certified occupational medicine specialist, indicated that appellant complained of right shoulder and neck stiffness and pain radiating distally into his triceps. Dr. Eagleson related that his pain woke him up at night and that he could not sleep on his right side. Appellant stated that the onset of this episode occurred three to four weeks ago, and that his pain had been recurring since he sustained a head and neck injury in March 2017 when he jammed his head on a trapeze. Dr. Eagleson noted that appellant was evaluated in the emergency room, at that time, and results from an x-ray taken then displayed cervical spine degenerative changes and a reversal of the normal cervical lordosis. Appellant was treated at that time with muscle relaxers, stretching, and heat. Dr. Eagleson conducted a physical examination of appellant, which revealed neck pain upon rotation and forward flexion. Mild limits to full right shoulder abduction were also noted. Appellant was provided with pain medication and told to alternately apply cold and heat. He was instructed to return to work on light duty, and the attached progress notes signed by Richard Emler, a physician assistant, listed appellant's work restrictions.

A February 22, 2018 x-ray of appellant's right shoulder interpreted by Dr. Marlo Pagano, a Board-certified radiologist, revealed a small calcific density adjacent to the greater tuberosity, which he indicated was likely calcific tendinitis, and mild-to-moderate degenerative changes in the right acromioclavicular joint.

February 28, 2018 progress notes by Dr. Eagleson indicated that appellant stated that there were no changes to his condition. Dr. Eagleson noted that a diagnostic test of appellant's right shoulder revealed a small globular density adjacent to the proximal humerus/greater tuberosity and mild-to-moderate degenerative changes in the right acromioclavicular joint. Appellant was instructed to return to work on light duty with increased restrictions.

A March 2, 2018 medical report by Dr. Keith Cordischi, a Board-certified orthopedic surgeon, noted that appellant presented with right shoulder pain. Dr. Cordischi stated that, at the start of February 2018, appellant was lifting a veteran off of a toilet when he felt immediate pain down the right side of his neck and into his shoulder with radiculopathy into his arm. Appellant described his neck pain as tight, stiff, and constant and indicated that his right shoulder pain was in his bicipital groove. He also reported decreased range of motion in his shoulder. Appellant further noted that his March 2017 injury of hitting his head on a lift handrail caused chronic upper traps spasms. Dr. Cordischi conducted a physical examination of appellant's right shoulder, which revealed trigger point tenderness throughout the upper traps, mild supraspinatus and biceps tendon

tenderness, and full range of motion with pain. He noted that appellant's right shoulder x-rays displayed calcific tendinitis in addition to mild acromioclavicular degenerative joint disease. Dr. Cordischi diagnosed right shoulder traumatic rotator cuff arthropathy, calcific tendinitis, and cervical spine radiculopathy. He gave appellant an injection in his right shoulder and prescribed medication.

March 12, 2018 progress notes by Mr. Emler indicated that appellant continued to complain of neck and shoulder pain. Mr. Emler's findings included right neck pain with an exacerbating injury and a history of chronic degenerative joint disease in the cervical spine.

On March 14, 2018 appellant accepted a light-duty assignment from the employing establishment. On March 21, 2018 the employing establishment requested a full development of appellant's claim.

A March 19, 2018 medical report by Dr. John Owens, a Board-certified physical medicine and rehabilitation specialist, indicated that appellant experienced neck pain, since his prior March 2017 incident, and that it was manageable until early February 2018 when he experienced a pulling-type traction injury in his right shoulder while assisting a patient. The recent incident caused shoulder pain, worsening pain in appellant's lateral neck muscles on the right, and numbness and tingling in the right shoulder extending down his right arm and towards his right hand. Appellant reported worsening pain when moving and laying on his shoulder and painful and restrictive cervical movements. Dr. Owens reviewed appellant's x-rays and conducted a physical examination which revealed tenderness upon palpation over the cervical paraspinals and traps on the right and the lateral subdeltoid bursa and bicipital tendon. It also indicated that appellant had a limited range of motion in his neck and shoulder. Dr. Owens diagnosed appellant with subacute chronic right-sided neck pain, possible degenerative joint disease and radiculopathy, and subacute right shoulder pain, which was likely a rotator cuff pathology including impingement and possible biceps tendinitis.

An April 3, 2018 magnetic resonance imaging (MRI) scan of appellant's cervical spine interpreted by Dr. Mark Lobell, a Board-certified radiologist, revealed multilevel disc disease resulting in multilevel significant spinal canal stenosis with fairly significant spinal canal cord flattening at multiple levels. Additionally, multilevel neuroforaminal narrowing was identified.

An April 12, 2018 medical report by Dr. Kelsi Tagliati, a Board-certified anesthesiologist and pain medicine specialist, indicated that appellant continued to complain of neck and shoulder pain. Dr. Tagliati diagnosed myofascial pain and treated him with trigger point injections. April 12, 2018 discharge instructions indicated that appellant had myofascial pain trigger point injections and instructed him on follow-up care for the injection sites.

April 13, 2018 progress notes by Dr. Eagleson indicated that appellant stated that he was feeling "pretty good," but still in pain. Dr. Eagleson's findings included right neck pain with an exacerbating injury and a history of chronic degenerative joint disease in the cervical spine. He continued to recommend light duty with work restrictions. An April 20, 2018 follow-up report by Dr. Eagleson indicated that appellant's condition had not changed. Dr. Eagleson repeated the findings from his previous report and continued to recommend light duty with work restrictions.

May 21, 2018 progress notes from Dr. Owens indicated that appellant continued to complain of neck and shoulder pain on the right side. Dr. Owens continued to diagnose appellant

with subacute chronic right-sided neck pain, possible degenerative joint disease and radiculopathy, and subacute right shoulder pain, which was likely a rotator cuff pathology including impingement and possible biceps tendinitis. He additionally diagnosed appellant with cervical spinal stenosis.

June 5, 2018 progress notes by Mr. Emler indicated that appellant continued to complain of right shoulder and neck pain. Appellant returned to work full time and reported increased pain at the end of his shift. Mr. Emler repeated Dr. Eagleson's previous findings and recommended that appellant continue with full-duty work.

A May 22, 2018 follow-up report from Dr. Eagleson indicated that appellant complained of shoulder pain, neck pain, and numbness from his shoulder extending into his fingers. Dr. Eagleson repeated his previous findings and recommended that appellant continue with full-duty work.

In a July 17, 2018 development letter, OWCP indicated that, when appellant's claim was received, it appeared to be a minor injury that resulted in minimal or no lost time from work, and that based on these criteria and because the employing establishment did not controvert the continuation of pay or challenge the merits of the case, payment of a limited amount of medical expenses was administratively approved. The merits of the claim, however, had not been formally considered. OWCP advised appellant that the documentation received to date was insufficient to support his claim for compensation benefits. It explained that the evidence of record was insufficient to establish that he sustained an injury in the performance of duty, as alleged. OWCP advised appellant of the factual and medical evidence necessary to establish his claim and attached a questionnaire for his completion. It afforded him 30 days to submit the requested factual and medical evidence.

A July 30, 2018 attending physician report (Form CA-20) by Dr. Eagleson noted that appellant's history of injury included pain in his right neck and shoulder from early February 2018 and a preexisting injury of a cervical strain and head contusion from March 2017. Dr. Eagleson diagnosed appellant with degenerative joint disease of the cervical spine. He checked the box marked "yes" indicating that the condition found was caused or aggravated by the employment activity described and replied that it was an aggravation. Dr. Eagleson recommended light duty, a consultation with a neurosurgeon, and listed his recommended work restrictions.

By decision dated August 21, 2018, OWCP denied appellant's traumatic injury claim, finding that the evidence of record failed to establish that a medical condition was diagnosed in connection with the February 1, 2018 accepted employment incident. It concluded, therefore, that the requirements had not been met to establish an injury as defined by FECA.

On March 7, 2019 appellant, through counsel, requested reconsideration.

September 25, 2018 medical records signed by Erica Ortega, a physician assistant, indicated that appellant presented with neck pain extending into his shoulders which was worse on his right side. Appellant also noted that he experienced frequent headaches. Ms. Ortega reported that appellant had a two-year history of neck pain radiating into his right shoulder with numbness and tingling radiating into his right upper extremity. She noted that in 2016 appellant hit his head on the bar of a patient's bed and that, prior to that, appellant did not experience any neck pain. Ms. Ortega additionally related that on June 23, 2018 a patient aggressively pushed appellant's head down, which aggravated his preexisting symptoms. Her findings included cervical

radiculopathy on appellant's right side that progressively worsened, and she noted that appellant's April 3, 2018 MRI scan revealed moderate-to-severe herniations at C3-4, C4-5, and C5-6. Ms. Ortega stated that, although it was impossible to say with 100 percent certainty, appellant's symptom onset seemed to be related to his work-related incident.

An October 16, 2018 operative report by Dr. Christopher Kager, a Board-certified neurosurgeon, noted that appellant was diagnosed with herniated nucleus pulposus at C3-4, C4-5, and C5-6 and indicated that he performed surgery on appellant's cervical spine.

A February 6, 2019 letter by Dr. Kager indicated that, although it was impossible to say with certainty, appellant's disc herniation and consequent surgery were a result of his work-related incidents as appellant described them. He then quoted appellant discussing his 2016 injury where he hit his head on the bar of a patient's bed and another injury which occurred "last month" where a patient pushed appellant's head down aggressively.

By decision dated June 4, 2019, OWCP modified its prior decision, finding that the evidence of record was sufficient to establish that a medical condition was diagnosed in connection with the February 1, 2018 accepted employment incident. However, it continued to deny appellant's claim, as the evidence of record failed to establish a causal relationship between appellant's diagnosed conditions and his February 1, 2018 accepted employment incident.

LEGAL PRECEDENT

An employee seeking benefits under FECA⁴ has the burden of establishing 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 of FECA,⁵ 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.⁶ 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.⁷

To determine if an employee sustained a traumatic injury in the performance of duty, OWCP begins with an analysis of whether fact of injury has been established.⁸ Fact of injury consists of two components that must be considered in conjunction with one another. The first component is whether the employee actually experienced the employment incident that allegedly

⁴ *Supra* note 2.

⁵ *J.P.*, Docket No. 19-0129 (issued April 26, 2019); *S.B.*, Docket No. 17-1779 (issued February 7, 2018); *Joe D. Cameron*, 41 ECAB 153 (1989).

⁶ *J.M.*, Docket No. 17-0284 (issued February 7, 2018); *R.C.*, 59 ECAB 427 (2008); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

⁷ *R.R.*, Docket No. 19-0048 (issued April 25, 2019); *L.M.*, Docket No. 13-1402 (issued February 7, 2014); *Delores C. Ellyett*, 41 ECAB 992 (1990).

⁸ *E.M.*, Docket No. 18-1599 (issued March 7, 2019); *T.H.*, 59 ECAB 388, 393-94 (2008).

occurred.⁹ The second component is whether the employment incident caused a personal injury.¹⁰ An employee may establish that an injury occurred in the performance of duty, as alleged, but fail to establish that the disability or specific condition for which compensation is being claimed is causally related to the injury.¹¹

Rationalized medical opinion evidence is required to establish causal relationship. The opinion of the physician must be based on a complete factual and medical background, 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 incident.¹²

In any case where a preexisting condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation, acceleration, or precipitation, the physician must provide a rationalized medical opinion that differentiates between the effects of the work-related injury or disease and the preexisting condition.¹³

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish right shoulder and neck conditions causally related to the accepted February 1, 2018 employment incident.

The medical reports by Dr. Eagleson and/or his physician assistant, Mr. Emler, noted that appellant complained of right shoulder and neck pain, recounted a March 2017 preexisting injury which occurred when appellant jammed his head on a trapeze, and an x-ray from March 2017 that displayed cervical spine degenerative changes and a reversal of the normal cervical lordosis. The reports indicated that Dr. Eagleson diagnosed right neck pain with an exacerbating injury and a history of chronic degenerative joint disease in the cervical spine. Dr. Eagleson did not specify what the exacerbating injury was or whether it exacerbated appellant's preexisting condition of degenerative joint disease in the cervical spine. The Board has held that 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.¹⁴ Additionally, the reports only signed by Mr. Elmer do not constitute competent medical evidence because certain healthcare providers such as physician assistants, nurse practitioners, physical therapists, and social workers are not considered "physician[s]" as defined under FECA.¹⁵ Moreover, the Board has held that pain is a symptom and not a compensable medical diagnosis.¹⁶

⁹ *L.T.*, Docket No. 18-1603 (issued February 21, 2019); *Elaine Pendleton*, 40 ECAB 1143 (1989).

¹⁰ *B.M.*, Docket No. 17-0796 (issued July 5, 2018); *John J. Carlone*, 41 ECAB 354 (1989).

¹¹ *J.P.*, *supra* note 5; *L.T.*, *supra* note 9; *Shirley A. Temple*, 48 ECAB 404, 407 (1997).

¹² *Dennis M. Mascarenas*, 49 ECAB 215 (1997).

¹³ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013); *see L.C.* Docket No. 19-1301 (issued January 29, 2020); *R.D.*, Docket No. 18-1551 (issued March 1, 2019).

¹⁴ *C.C.*, Docket No. 19-0442 (issued July 22, 2019).

¹⁵ 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t).

¹⁶ *T.G.*, Docket No. 19-0904 (issued November 25, 2019).

Dr. Cordischi's March 2, 2018 medical report noted that appellant presented with right shoulder pain. He stated that, at the start of February 2018, appellant was lifting a veteran off of a toilet when he felt immediate pain down the right side of his neck and into his shoulder with radiculopathy into his arm. Dr. Cordischi also noted appellant's March 2017 preexisting injury where he hit his head on a lift handrail, which, according to appellant, caused chronic upper trapezius spasms. He conducted a physical examination, noted that appellant's right shoulder x-rays displayed calcific tendinitis in addition to mild acromioclavicular degenerative joint disease, and diagnosed right shoulder traumatic rotator cuff arthropathy, calcific tendinitis, and cervical spine radiculopathy. As stated above, in any case where a preexisting condition involving the same part of the body is present and the issue of causal relationship, therefore, involves aggravation, acceleration, or precipitation, Dr. Cordischi must provide a rationalized medical opinion that differentiates between the effects of the work-related injury or disease and the preexisting condition.¹⁷ As Dr. Cordischi did not specifically differentiate between appellant's preexisting condition(s) and the effects of the accepted February 1, 2018 employment incident, his report is insufficient to establish causal relationship.

Dr. Owen's medical reports noted that appellant presented with neck and shoulder pain with right shoulder numbness and tingling extending down his right arm. He recounted appellant's March 2017 prior injury causing neck pain and stated that a February 2018 pulling-type traction injury in appellant's right shoulder worsened his pain. Dr. Owens reviewed appellant's x-rays and MRI scan, conducted a physical examination, and diagnosed subacute chronic right-sided neck pain, possible degenerative joint disease and radiculopathy, subacute right shoulder pain, which was likely a rotator cuff pathology including impingement and possible biceps tendinitis, and cervical spinal stenosis. As stated above, the Board has held that pain is a symptom and not a compensable medical diagnosis.¹⁸ Additionally, "possible" degenerative joint disease and radiculopathy and "likely" a rotator cuff pathology including impingement and possible biceps tendinitis are not firm diagnoses.¹⁹ Lastly, as stated above, in any case where a preexisting condition involving the same part of the body is present and the issue of causal relationship therefore involves aggravation, acceleration, or precipitation, the physician must provide a rationalized medical opinion that differentiates between the effects of the work-related injury or disease and the preexisting condition.²⁰

Dr. Tagliati's April 12, 2018 medical report indicated that appellant complained of neck and shoulder pain and diagnosed appellant with myofascial pain. The Board has held that pain is a symptom and not a compensable medical diagnosis.²¹

Dr. Owen's June 30, 2018 attending physician's report (Form CA-20) noted that appellant's history of injury included pain in his right neck and shoulder from early February 2018 and a preexisting injury of a cervical strain and head contusion from March 2017. Dr. Owen

¹⁷ *Supra* note 13.

¹⁸ *Supra* note 16.

¹⁹ *See V.D.*, Docket No. 16-1345 (issued September 27, 2017); *see R.G.*, Docket No. 14-0113 (issued April 25, 2014).

²⁰ *Supra* note 13.

²¹ *Supra* note 16.

diagnosed degenerative joint disease of the cervical spine. Dr. Eagleson checked the box marked “yes” in response to the question “do you believe that the condition found was caused or aggravated by the employment activity described” and stated that it was an aggravation. When a physician’s opinion on causal relationship consists only of checking a box marked “yes” in response to a form question, without explanation or rationale, that opinion has limited probative value and is insufficient to establish a claim.²²

September 25, 2018 medical records signed by Ms. Ortega indicated that appellant presented with neck pain extending into his shoulders and headaches. Ms. Ortega referenced appellant’s preexisting injury of hitting his head on the bar of a patient’s bed and a June 23, 2018 injury when a patient pushed appellant’s head down. She diagnosed cervical radiculopathy and moderate to severe herniations at C3-4, C4-5, and C5-6. She stated that, although it was impossible to say with 100 percent certainty, appellant’s symptom onset seemed to be related to his work-related incident. As stated above, certain healthcare providers such as physician assistants, nurse practitioners, physical therapists, and social workers are not considered “physician[s]” as defined under FECA.²³

Dr. Kager’s October 16, 2018 operative report indicated that appellant was diagnosed with herniated nucleus pulposus at C3-4, C4-5, and C5-6 and noted the surgeries performed on appellant. Dr. Kager did not mention the accepted February 1, 2018 incident or otherwise attribute appellant’s neck and shoulder conditions to his employment. The Board has held that 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.²⁴

Dr. Kager’s February 6, 2019 letter stated that although it was impossible to say with certainty, appellant’s disc herniation and consequent surgery were a result of his work-related incidents as appellant described them. Dr. Kager then quoted appellant discussing his 2016 injury where he hit his head on the bar of a patient’s bed and another injury which occurred “last month” where a patient pushed appellant’s head down aggressively. This letter also did not mention the accepted February 1, 2018 employment incident. As stated above, the opinion of the physician must be based on a complete factual and medical background.²⁵

Appellant also submitted a February 22, 2018 x-ray of his right shoulder and an April 3, 2018 cervical spine MRI scan. The Board has explained that diagnostic studies lack probative value as they do not address whether the employment incident caused any of the diagnosed conditions.²⁶

The Board finds that the record lacks medical evidence establishing a causal relationship between appellant’s right shoulder and neck conditions and the February 1, 2018 employment incident. Thus, appellant has not met his burden of proof.

²² *K.R.*, Docket No. 19-0375 (issued July 3, 2019).

²³ *Supra* note 15.

²⁴ *C.C.*, *supra* note 14.

²⁵ *Supra* note 12.

²⁶ *N.B.*, Docket No. 19-0221 (issued July 15, 2019).

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 establish right shoulder and neck conditions causally related to the accepted February 1, 2018 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the June 4, 2019 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 2, 2020
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

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