United States Department of Labor
Employees' Compensation Appeals Board

C.S., Appellant	)	
and	)	**Docket No. 21-0354**
	)	**Issued: June 27, 2023**
FEDERAL JUDICIARY, ADMINISTRATIVE OFFICE OF THE U.S. COURTS, Washington, DC, Employer	)	

Appearances:
Stephen Scavuzzo, 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
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 4, 2021 appellant, through counsel, filed a timely appeal from a July 9, 2020 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 met her burden of proof to establish a medical condition causally related to the accepted October 22, 2018 employment incident.

[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.*

FACTUAL HISTORY

On December 20, 2018 appellant, then a 48-year-old information technology specialist, filed a traumatic injury claim (Form CA-1) alleging that, on October 22, 2018, she sustained multiple injuries to her neck, lower back, right arm, and right shoulder when a woman fainted and collapsed into appellant's right arm while in the performance of duty. She explained that she ran from the back of the auditorium and onto the stage to catch the woman as she collapsed. Appellant did not stop work.

In an October 29, 2018 report, Emily Litten, a physician assistant, diagnosed asthma, allergic rhinitis, chronic back pain, insomnia, post-traumatic stress disorder (PTSD), and hand pain.

In a November 7, 2018 procedure report, Dr. Ashish G. Shanbhag, Board-certified in pain medicine, diagnosed spondylosis without myelopathy or radiculopathy in the cervical region. On November 8, 2018 Dr. Shanbhag noted that appellant presented for follow up to her chronic spinal pain issues. He related that "sitting, standing, walking, lifting, lying flat, [and] driving" were aggravating factors for her pain. Dr. Shanbhag conducted a physical examination and diagnosed cervical facet syndrome, cervical enthesopathy, drug dependence, chronic pain, opioid dependence, lumbar facet syndrome, choric pain syndrome, and cervicalgia.

In reports dated November 12, 14, and 16, 2018, Dr. Shanbhag noted that appellant underwent diagnostic cervical medial branch block procedure. He diagnosed spondylosis without myelopathy or radiculopathy in the cervical region.

A November 30, 2018 x-ray of the right hand demonstrated normal results. A right shoulder x-ray of even date revealed degenerative changes involving the right acromioclavicular joint. In a medical report of even date, Dr. Priya Ghadge, Board-certified in family practice, conducted a physical examination and diagnosed hand joint pain and shoulder joint pain.

In a December 7, 2018 medical report, Dr. Shanbhag reiterated his earlier findings and diagnoses. In a procedure report of even date, he noted that appellant underwent a prolotherapy injection and diagnosed cervical spondylosis.

On December 14, 2018 appellant was treated by Dr. Shanbhag for follow up to her chronic pain issues. In a report dated December 14, 2018, he noted that "sitting, standing, walking, lifting, lying flat, driving, cold/damp weather, and coughing/sneezing" were aggravating factors for her pain. Dr. Shanbhag conducted a physical examination and diagnosed chronic pain, cervical enthesopathy, cervical facet syndrome, other cervical disc displacement at C6-C7 level, lumbosacral radiculopathy, lumbar facet syndrome, opioid dependence, lumbosacral enthesopathy, chronic pain syndrome, cervical radiculopathy, and low back pain (lumbago). In a procedure report of even date, he noted that appellant underwent a prolotherapy injection and diagnosed cervicothoracic spondylosis.

In a December 18, 2018 procedure report, Dr. Shanbhag noted that appellant underwent a prolotherapy injection and diagnosed lumbosacral spondylosis.

In a January 4, 2019 medical report, Dr. Shanbhag noted that appellant experienced right shoulder pain after catching a woman from falling at work. He conducted a physical examination

and diagnosed chronic pain, anxiety, PTSD, lumbar facet syndrome, cervicalgia, low back pain (lumbago), suprascapular neuropathy, and right shoulder pain.

A January 8, 2019 right shoulder arthrogram demonstrated a focal superior labrum anterior posterior (SLAP) tear with extension of the superior and posterior labrum, minimal rotator cuff tendinosis, and impingement in the acromioclavicular joint. In a medical report of even date, Dr. Shanbhag conducted a physical examination and diagnosed suprascapular neuropathy, right shoulder pain, chronic pain, cervical facet syndrome, PTSD, lumbar facet syndrome, and low back pain (lumbago).

In a January 21, 2019 medical report, Dr. Shanbhag conducted a physical examination and diagnosed suprascapular neuropathy, tendinosis, and superior glenoid labrum lesion of right shoulder.

In a January 23, 2019 procedure report, Dr. Shanbhag noted that appellant underwent an intra-articular shoulder joint injection in the right shoulder and diagnosed right rotator cuff syndrome. In a medical report of even date, Dr. Hajeer Sabet, a Board-certified orthopedic surgeon, noted that appellant presented with neck and right shoulder pain. He also noted that appellant had a history of pain for the past two or three months after she caught a falling woman, injuring her arm. Dr. Sabet conducted a physical examination and diagnosed a right shoulder SLAP tear, rotator impingement, and tendinosis.

On January 31, 2019 Dr. Shanbhag conducted a physical examination and diagnosed right shoulder pain and superior glenoid labrum lesion of right shoulder. In a procedure report of even date, he noted that appellant underwent an intra-articular shoulder joint injection in the right shoulder and diagnosed right rotator cuff syndrome.

In a February 11, 2019 procedure report, Dr. Shanbhag noted that appellant underwent a therapeutic right shoulder joint injection and diagnosed right rotator cuff syndrome.

Dr. Sabet, in a report dated February 19, 2019, diagnosed ongoing right shoulder pain and right shoulder impingement syndrome.

In a February 25, 2019 medical report, Dr. Ghadge noted that appellant underwent neck surgery. In a procedure report of even date, Dr. Shanbhag indicated that appellant underwent diagnostic thoracic medial branch block procedure and diagnosed spondylosis without myelopathy or radiculopathy in the thoracic region. In a medical report of even date, he noted that appellant presented with right shoulder pain as well as right mid-back pain. Dr. Shanbhag diagnosed right shoulder pain, chronic pain, thoracic spine pain, thoracic facet syndrome.

In a February 26, 2019 procedure report, Dr. Shanbhag noted that appellant presented with right mid-back pain and underwent diagnostic thoracic medial branch block procedure. He diagnosed spondylosis without myelopathy or radiculopathy in the thoracic region.

In a March 6, 2019 operative report, Dr. Sabet noted that appellant underwent right shoulder subacromial decompression, arthroscopic labral debridement, and rotator cuff debridement. He diagnosed right shoulder subacromial impingement syndrome, a right shoulder labral tear, and rotator cuff tendinosis.

In a March 14, 2019 medical report, Dr. Sabet conducted a physical examination and diagnosed status post right shoulder rotator cuff debridement.

Appellant underwent physical therapy treatments from March 25 through May 13, 2019.

In a May 9, 2019 medical report, Dr. Sabet conducted a physical examination and diagnosed cervical stenosis and pain as well as facet pain.

A May 29, 2019 magnetic resonance imaging (MRI) scan of the spine revealed spondylosis causing neural foramina narrowing at C2-3 level on the left, C3-4 level on the left, C4-5 level on the left, with impingement upon the existing left C3, left C4, and the left C5 nerve roots. It also demonstrated central canal stenosis at C3-4 through C6-7 levels.

In a June 11, 2019 medical report, Dr. Sabet conducted a physical examination and diagnosed cervical stenosis, radiculopathy, and neck pain.

A June 14, 2019 x-ray of the cervical spine revealed no fracture or osseous destruction but demonstrated stable degenerative changes at the C5-6 level.

On June 18, 2019 Dr. Ghadge conducted a physical examination and diagnosed persistent insomnia, PTSD, displacement of cervical intervertebral disc without myelopathy.

A June 24, 2019 cervical spine x-ray demonstrated operative changes from multilevel anterior fusion. In an operative report of even date, Dr. Sabet diagnosed cervical spinal stenosis at C4-5 and C5-6 levels, cervical radiculopathy, and degenerative disc disease at the cervical spine.

On June 25, 2019 Dr. Sabet conducted a physical examination and diagnosed neck swelling with possible hematoma of the cervical spine with dysphonia and dysphagia. In an operative report of even date, he diagnosed left neck hematoma and noted that he performed incision and drainage of a neck hematoma and intraoperative microbiology cultures.

In a July 2, 2019 medical report, Dr. Sabet indicated that appellant underwent anterior cervical discectomy and fusion.

A July 5, 2019 cervical spine x-ray demonstrated new postsurgical changes status post C4-5 and C5-6 anterior fusion.

In a July 10, 2019 medical report, Dr. Ghadge diagnosed right shoulder joint pain.

In an October 31, 2019 form report, Dr. Sabet noted that appellant should be excused from work for the period June 24 through July 24, 2019. He indicated that she underwent three surgeries within four months and experienced significant pain.

In a December 5, 2019 development letter, OWCP informed appellant of the deficiencies of her claim. It advised her of the type of factual and medical evidence needed to establish her claim and afforded her 30 days to submit the necessary evidence.

In a December 12, 2019 memorandum, appellant's supervisor, S.M., indicated that appellant notified him of the October 22, 2018 employment incident within 24 hours of the incident.

A December 16, 2019 cervical spine x-ray revealed postsurgical and degenerative changes but demonstrated no evidence of acute fracture or hardware complication.

In a January 3, 2020 statement, appellant contended that she timely notified her direct supervisor of the August 22, 2018 employment incident. She further contended that she sustained more than a minor injury from the employment incident and asserted that she never had any shoulder issue prior to the August 22, 2018 employment incident. Appellant acknowledged that she previously experienced some pain in her neck prior to the employment incident, but never severe enough to require surgery.

In a January 7, 2020 report, Dr. Danielle S. Cherrick, a Board-certified physiatrist, noted that appellant was under her care. She recommended that appellant work remotely for three full days per week, starting on January 13, 2020.

By decision dated January 14, 2020, OWCP denied appellant's claim, finding that the evidence of record was insufficient to establish that appellant's diagnosed medical conditions were causally related to her accepted October 22, 2018 employment incident.

In a February 5, 2020 note, Rebekka Miller, a nurse practitioner, modified appellant's return to work schedule to extend it through March 10, 2020.

In a March 6, 2020 report, Dr. Cherrick noted that appellant was under her care since October 2018 for lower lumbar pain, facet joint syndrome, and multiple herniated discs. She reported that she was injured at work around October 2018 and indicated that she underwent three surgeries on her shoulder and neck. Dr. Cherrick related that appellant made extensive progress over her recovery period. She described multiple obstacles that appellant still experienced that prevented her from fully returning to work. Dr. Cherrick recommended that appellant work remotely until she was completely recovered.

A March 16, 2020 cervical spine MRI scan revealed anterior cervical fusion with straightening of the cervical lordosis, stable narrowing of the C3-4 neuroforamina, and stable degenerative changes at C4-5 and C5-6 levels.

In an April 6, 2020 narrative report, Dr. Cherrick noted that appellant was initially seen on October 17, 2017, prior to the accepted October 22, 2018 employment incident, with a complaint of extreme lower lumbar pain and mild cervical pain, with a history of sleep disturbance, headaches, PTSD, and lower lumbar disc disease and facet joint syndrome. She noted that appellant's 2017 MRI scan revealed preexisting degenerative disc disease involving the lumbosacral spine, left paracentral-lateral disc protrusion at L3-4 level without definite evidence of nerve root impingement, small left paracentral disc protrusion at L4-5 level impinging upon the left L5 nerve root, and small central disc osteophyte complex at the L5-S1 level impinging upon the right S1 nerve root. Dr. Cherrick related that appellant was treated for her cervical spine and neck issues, was diagnosed with lumbosacral spondylosis, and returned to work after experiencing significant progress with her treatments. She reported that after the accepted October 22, 2018 employment incident, however, appellant's pain and issues significantly worsened. Dr. Cherrick then reviewed appellant's diagnostic studies and summarized her treatment history, including her March 6, 2019 right shoulder debridement and June 24, 2019 neck fusion.

Dr. Cherrick noted that the November 30, 2018 right shoulder x-ray revealed degenerative changes in the right acromioclavicular joint and the arthrogram of the right shoulder demonstrated

focal tendinosis in the supraspinatus without a tear in the rotator cuff, as well as a focal SLAP tear in the superior and posterior labrum. She also noted that the March 16, 2020 cervical spine MRI scan was compared to appellant's presurgical 2019 MRI scan and revealed that she had minimal disc bulge with bilateral facet joint uncovertebral joint hypertrophic changes resulting in moderate-to-severe left neural foraminal stenosis at C3-4 level and mild-to-moderate bilateral neuroforaminal stenosis at C5-6 level. Dr. Cherrick further indicated that appellant's attempt to return to work exacerbated her work-related injury. She opined, based on the diagnostic studies, and due to appellant having no symptoms prior to the October 22, 2018 employment incident, that the accepted October 22, 2018 employment incident aggravated appellant's preexisting conditions and most likely caused new issues that she never experienced. Dr. Cherrick explained that there were changes between appellant's latest cervical spine MRI scan and the original MRI scan performed prior to the accepted October 22, 2018 employment incident. She indicated that she performed a steroidal injection on appellant's right shoulder on September 25, 2019 and then again on March 6, 2020. Dr. Cherrick noted that appellant underwent physical therapy treatment without relief. She concluded that while appellant had preexisting issues with her lower back that was actively treated, the accepted October 22, 2018 employment incident aggravated her preexisting conditions and caused new injuries to her shoulder.

In an April 21, 2020 statement, appellant contended that a new report from Dr. Cherrick would establish causal relationship.

On May 28, 2020 appellant requested reconsideration.

By decision dated July 9, 2020, OWCP denied modification of its January 14, 2020 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] has the burden of proof to establish the essential elements of his or her claim, including 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,[4] 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.[5] 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.[6]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether fact of injury has been established. There are two components involved in establishing fact of injury. The first component is whether the

[3] *Id*.

[4] *F.H.*, Docket No.18-0869 (issued January 29, 2020); *J.P.*, Docket No. 19-0129 (issued April 26, 2019); *Joe D. Cameron*, 41 ECAB 153 (1989).

[5] *L.C.*, Docket No. 19-1301 (issued January 29, 2020); *J.H.*, Docket No. 18-1637 (issued January 29, 2020); *James E. Chadden, Sr.*, 40 ECAB 312 (1988).

[6] *P.A.*, Docket No. 18-0559 (issued January 29, 2020); *K.M.*, Docket No. 15-1660 (issued September 16, 2016); *Delores C. Ellyett*, 41 ECAB 992 (1990).

employee actually experienced the employment incident at the time and place, and in the manner alleged. The second component is whether the employment incident caused a personal injury.[7]

The medical evidence required to establish causal relationship between a claimed specific condition and an employment incident is rationalized medical opinion evidence.[8] 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 specific employment incident identified by the employee.[9]

In a case in which 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.[10]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish a medical condition causally related to the accepted October 22, 2018 employment incident.

In her April 6, 2020 narrative report, Dr. Cherrick detailed a history of appellant's treatment and diagnostic studies since October 17, 2017 when she was previously treated for preexisting cervical spine and neck issues. Appellant complained that her pain and issues significantly worsened after the accepted October 22, 2018 employment incident. Dr. Cherrick provided a detailed interpretation of the November 30, 2018 x-rays of the right shoulder and right hand and the March 16, 2020 cervical spine MRI scan, which was compared to the 2017 study. She opined, based on the changes in diagnostic studies, and due to appellant having no symptoms prior to the accepted October 22, 2018 employment incident, that the accepted employment incident aggravated appellant's preexisting conditions and most likely caused new issues that she never experienced. However, Dr. Cherrick provided no rationale explaining how, physiologically, the specific movements involved in the accepted October 22, 2018 employment incident caused or aggravated the diagnosed conditions. The Board has held that a medical opinion must explain how the implicated employment factors physiologically caused, contributed to, or aggravated the specific diagnosed conditions.[11] A well-rationalized opinion is particularly warranted when there

[7] *T.H.*, Docket No. 19-0599 (issued January 28, 2020); *K.L.*, Docket No. 18-1029 (issued January 9, 2019); *John J. Carlone*, 41 ECAB 354 (1989).

[8] *S.S.*, Docket No. 19-0688 (issued January 24, 2020); *A.M.*, Docket No. 18-1748 (issued April 24, 2019); *Robert G. Morris*, 48 ECAB 238 (1996).

[9] *T.L.*, Docket No. 18-0778 (issued January 22, 2020); *Y.S.*, Docket No. 18-0366 (issued January 22, 2020); *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[10] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013); *see E.W.*, Docket 20-0760 (issued January 11, 2021); *K.G.*, Docket No. 18-1598 (issued January 7, 2020); *M.S.*, Docket No. 19-0913 (issued November 25, 2019).

[11] *S.C.*, Docket No. 20-0492 (issued May 6, 2021); *R.S.*, Docket No. 19-1774 (issued April 3, 2020).

is a history of a preexisting condition.[12] Therefore, Dr. Cherrick's opinion is of limited probative value and insufficient to meet appellant's burden of proof.

In January 23, 2019 and March 6, 2020 reports, Drs. Sabet and Cherrick related the history of injury and diagnosed a right shoulder SLAP tear, rotator impingement, tendinosis, lower lumbar pain, facet joint syndrome, and multiple herniated discs. However, they did not provide an opinion on causal relationship. 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.[13] This evidence is therefore of no probative value and is insufficient to establish appellant's claim.

In reports dated November 7, 2018 through June 25, 2019, Drs. Shanbhag, Sabet, and Ghadge conducted a physical examination and provided multiple diagnoses. However, they failed to offer an opinion on causation. As noted above, 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] Thus, these reports are insufficient to establish the claim.

In medical reports dated November 30, 2018 and July 10, 2019, Dr. Ghadge diagnosed hand joint pain and right shoulder joint pain. Similarly, in his June 25, 2019 medical report, Dr. Sabet diagnosed neck swelling but offered no opinion on causal relationship. As noted above, a medical report lacking an opinion on causal relationship is of no probative value.[15] Thus, these reports are insufficient to establish appellant's claim.

In medical reports dated February 25 through October 31, 2019, Drs. Ghadge and Sabet noted that appellant underwent multiple surgeries. In a January 7, 2020 report, Dr. Cherrick noted that appellant was under her care. However, none of these reports provided an opinion on causal relationship. The Board has held that a medical report is of no probative value if it does not provide an opinion as to whether the accepted employment incident caused or contributed to the claimed condition(s).[16] Thus, this evidence also is of no probative value and insufficient to establish the claim.

Appellant also submitted multiple documents from a physician assistant, a physical therapist, and a nurse practitioner. The Board has held that certain healthcare providers such as physician assistants, nurse practitioners, physical therapists, and social workers are not considered

[12] *J.C.*, Docket No. 20-1509 (issued May 25, 2021); *J.L.*, Docket No. 20-0717 (issued October 15, 2020); *E.B.*, Docket No. 17-1497 (issued March 19, 2019).

[13] *See R.C.*, Docket No. 19-0376 (issued July 15, 2019); *L.B.*, Docket No. 18-0533 (issued August 27, 2018); *D.K.*, Docket No. 17-1549 (issued July 6, 2018).

[14] *Id*.

[15] *Id*.

[16] *Id*.

physicians as defined under FECA.[17] Consequently, their medical findings and/or opinions will not suffice for purposes of establishing entitlement to FECA benefits.

The record also contains diagnostic studies. The Board has held that diagnostic studies, standing alone, lack probative value on the issue of causal relationship, as they do not provide an opinion as to whether the employment incident caused any of the diagnosed conditions.[18] Accordingly, these diagnostic studies are insufficient to establish appellant's claim.

Finally, appellant also submitted a June 25, 2019 after visit summary from an unidentifiable healthcare provider. The Board has held that reports that are unsigned or bear an illegible signature lack proper identification and cannot be considered probative medical evidence as the author cannot be identified as a physician.[19] Therefore, this report is also insufficient to establish the claim.

As the medical evidence of record is insufficient to establish causal relationship between appellant's diagnosed conditions and the accepted October 22, 2018 employment incident, the Board finds that 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 medical condition causally related to the accepted October 22, 2018 employment incident.

[17] Section 8101(2) of FECA provides that physician "includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law." 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t). *See also* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3a(1) (January 2013); *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); *C.P.*, Docket No. 19-1716 (issued March 11, 2020) (physician assistants are not considered physicians as defined under FECA); *R.L.*, Docket No. 19-0440 (issued July 8, 2019) (nurse practitioners and physical therapists are not considered physicians as defined under FECA).

[18] *See K.C.*, Docket No. 20-1325 (issued May 5, 2021); *C.B.*, Docket No. 20-0464 (issued July 21, 2020).

[19] *T.D.*, Docket No. 20-0835 (issued February 2, 2021); *R.C.*, Docket No. 20-1525 (issued June 8, 2021); *I.M.*, Docket No. 19-1038 (issued January 23, 2020); *T.O.*, Docket No. 19-1291 (issued December 11, 2019); *Merton J. Sills*, 39 ECAB 572, 575 (1988).

ORDER

IT IS HEREBY ORDERED THAT the July 9, 2020 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: June 27, 2023
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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