United States Department of Labor
Employees' Compensation Appeals Board

A.S., Appellant	)	
and	)	**Docket No. 15-0696**
	)	**Issued: August 15, 2016**
U.S. POSTAL SERVICE, CHICAGO NETWORK DISTRIBUTION CENTER, Forest Park, IL, Employer	)	

Appearances:
Alan J. Shapiro, 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
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On February 12, 2015 appellant, through counsel, timely appealed a January 21, 2015 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 the claim.[3]

[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's 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.*

[3] The case record provided to the Board includes evidence received after OWCP issued its January 21, 2015 decision. The Board is precluded from considering evidence that was not in the case record at the time OWCP rendered its final decision. 20 C.F.R. § 501.2(c)(1).

ISSUE

The issue is whether appellant sustained an injury in the performance of duty on March 18, 2014.

FACTUAL HISTORY

Appellant, a 49-year-old mail handler and forklift operator, filed a traumatic injury claim (Form CA-1) alleging that she injured her neck, shoulders, hands/wrists, and lower back while driving a forklift on March 18, 2014.[4] She was treated in the (Loyola University Medical Center) emergency room (ER) that same day and received a diagnosis of neck strain. The ER physician, Dr. Ethan J. Sterk, Board-certified in both internal medicine and emergency medicine, also completed an attending physician's report (Form CA-20). He indicated that appellant was involved in a forklift incident and suffered a neck strain. Dr. Sterk reported that appellant's cervical spine x-rays were normal.

On March 24, 2014 Dr. Doré E. DeBartolo, a Board-certified family practitioner, diagnosed cervical strain and referred appellant for physical therapy. She also submitted a work status form report, which noted that appellant had sustained an employment-related injury on March 18, 2014, and was limited to performing sedentary work. Dr. DeBartolo also provided an April 3, 2014 duty status report (Form CA-17) that similarly included a diagnosis of cervical strain with a March 18, 2014 date of injury.

OWCP received physical therapy treatment records covering the period April 1 to 23, 2014.

By decision dated May 5, 2014, OWCP denied appellant's claim because the medical evidence failed to demonstrate a causal relationship between her cervical strain and the March 18, 2014 forklift incident.

Appellant's counsel timely requested a hearing before an OWCP hearing representative, which was held on December 1, 2014. While the case was pending before the Branch of Hearings and Review, OWCP received additional medical evidence, which included physical therapy records from April 25 through July 23, 2014. Additionally, it received various medical reports and treatment notes from Dr. DeBartolo and her colleague, Dr. Gregory L. Primus, a Board-certified orthopedic surgeon, who ultimately performed a left carpal tunnel release.

Dr. DeBartolo's March 24, 2014 treatment notes indicated that appellant presented with complaints of neck pain related to a March 18, 2014 work incident. Appellant reported that she was operating a forklift when the wheel fell off and the axle broke causing her to lose control of the machine and hit a guardrail. Dr. DeBartolo reported a whiplash-type injury and noted that appellant had been taken by ambulance to the ER on the date of injury. Six days after the initial onset, appellant reported posterior neck pain, which she characterized as severe, constant, dull,

[4] A mechanical failure involving the rear wheel and axle caused appellant to lose control of the forklift, which then struck a guardrail and a wall. Appellant stopped work following the March 18, 2014 forklift incident. She has an accepted claim for a left knee injury sustained on September 20, 2011.

stabbing, cramping, and pulling. The pain radiated to the intrascapular area, right shoulder, and right arm. Appellant also reported occasional right hand numbness. Additional symptoms included neck stiffness and right upper extremity paresthesia, particularly around appellant's thumb and index finger. Dr. DeBartolo provided results on examination and reviewed recent cervical x-rays that showed C3-C6 mild degenerative disc disease with endplate sclerosis, osteophytes, and facet arthropathy. She diagnosed cervical strain, prescribed a topical analgesic and Naproxen, and referred appellant for physical therapy. Dr. DeBartolo explained that appellant's complaints were most consistent with a cervical strain, which typically improves over the course of a few weeks with conservative treatment. In addition to medications and physical therapy, she recommended activity modifications that included no overhead lifting, limited neck extension, and work/gym/sports restrictions.

Dr. DeBartolo also provided a Form CA-20 dated April 24, 2014 which identified March 18, 2014 as the date of injury, and noted that appellant had been operating a forklift when the wheel came off the axle. She also reported a jarring sensation, and noted that appellant hit a guardrail, injuring her neck. Dr. DeBartolo noted that x-rays revealed mild degenerative joint disease at C3-C6. On physical examination there was decreased range of motion and tenderness to palpation in the paraspinal region and midline C3-C7. Dr. DeBartolo diagnosed cervical strain and explained that the condition was employment related because the "jarring [and] impact" caused appellant's neck pain. She also advised that appellant was able to perform light-duty, sedentary work effective March 24, 2014.

When appellant returned for follow up on May 22, 2014, Dr. DeBartolo reported improvement with respect to her neck pain. However, appellant complained of constant numbness down her left arm into all fingers. Dr. DeBartolo recommended continued conservative care, a cervical magnetic resonance imaging (MRI) scan, and a left upper extremity electromyogram (EMG) and nerve conduction study (NCS).

A May 30, 2014 NCS was consistent with left median nerve entrapment/compression at the wrist (carpal tunnel syndrome). An EMG study was not performed.

On June 5, 2014 Dr. DeBartolo referred appellant for occupational therapy for left carpal tunnel syndrome and advised appellant to continue with her home exercise program. Additionally, she submitted a new Form CA-17 for modified-duty work based on appellant's injury-related cervical strain and carpal tunnel syndrome. Dr. DeBartolo's June 5, 2014 treatment notes indicated that appellant's symptoms had improved since her last visit. While her neck was much better, appellant continued to experience stiffness, as well as numbness in the left hand. Dr. DeBartolo reported that a recent MRI scan was unremarkable, but appellant's May 30, 2014 electrodiagnostic study revealed left median nerve compression at the wrist. She diagnosed cervical strain and carpal tunnel syndrome. Dr. DeBartolo recommended continued conservative care and a wrist splint, and advised appellant to follow up in one month.

Dr. DeBartolo's July 10, 2014 treatment notes indicated that appellant had been attending therapy and using a wrist brace, both of which helped. However, when appellant removed her wrist brace, the numbness, tingling, and pain returned. Dr. DeBartolo continued to diagnose cervical strain and carpal tunnel syndrome. When appellant returned for follow up on July 24, 2014, she received a left wrist corticosteroid injection.

In a July 25, 2014 narrative report, Dr. DeBartolo indicated that she had been treating appellant since March 24, 2014 for a work-related injury sustained on March 18, 2014 when appellant lost control of a forklift. She reported that the forklift's rear wheel and axle broke, causing it to spin out and strike a guardrail and a wall. Dr. DeBartolo further noted that appellant was forcefully whipped sideways then forward, which caused a whiplash-type injury to her neck, shoulders, hands, and wrist. She indicated that appellant was initially taken by ambulance to the ER. When Dr. DeBartolo first saw appellant on March 24, 2014 she complained of neck and shoulder pain with numbness and tingling down the left arm. She further noted that appellant had been diagnosed with cervical strain and carpal tunnel syndrome. Dr. DeBartolo indicated that appellant's treatment thus far consisted of physical therapy, anti-inflammatory pain medication, and a carpal tunnel steroid injection. She also stated that appellant was able to perform light-duty work, but the employing establishment was unable to accommodate appellant's work restrictions. Lastly, Dr. DeBartolo indicated that, if appellant's pain and paresthesia did not improve by her next visit, she may be a candidate for carpal tunnel release.

Dr. Primus examined appellant on August 21, 2014. He reported a March 18, 2014 date of injury. Dr. Primus noted that appellant had good relief from her steroid injection; however, it lasted only three weeks. He diagnosed cervical strain and carpal tunnel syndrome, and recommended left carpal tunnel release.

In a September 17, 2014 attending physician's report (Form CA-20), Dr. DeBartolo indicated that appellant was operating a forklift on March 18, 2014 when the rear wheel and axle broke off causing whiplash to her neck, hands and wrist. She also reported that there was no history or evidence of concurrent or preexisting injury. Dr. DeBartolo indicated that appellant's electrodiagnostic study was positive for carpal tunnel syndrome. While her cervical MRI scan was within normal limits, appellant's x-rays showed mild degenerative joint disease at C3-C6. Dr. DeBartolo diagnosed employment-related cervical strain and left carpal tunnel syndrome. She explained that "the forceful whiplash [and] axial loading" caused appellant's symptoms.

Appellant continued to follow up with both Dr. Primus and Dr. DeBartolo on September 18, October 16, and 23, 2014. Dr. DeBartolo's diagnoses remained the same while appellant awaited surgery on her left wrist. Appellant was restricted to sedentary work and her limitations included no operating heavy machinery -- including a forklift, no repetitive grasping, and no use of vibratory tools.

In an October 24, 2014 letter, Dr. DeBartolo essentially reiterated her July 25, 2014 report regarding appellant's history of injury and diagnoses. In this latest report, she added that appellant's "injuries were directly and causally related to the work injury on [March 18, 2014]."

Dr. Primus saw appellant on November 20 and December 4, 2014, before performing a left carpal tunnel release on December 10, 2014. In a December 19, 2014 postoperative report, he indicated that appellant was doing much better following surgery and she no longer had any numbness. Dr. Primus advised her to follow up in one week, at which time he anticipated removing appellant's sutures. When she returned on December 26, 2014, he removed appellant's sutures and recommended therapy for improved range of motion and strengthening. Dr. Primus also advised appellant to remain off work and to follow up in one month. Additionally, he submitted a December 26, 2014 work status and recommendations form report.

Appellant's diagnoses included cervical strain and status post left carpal tunnel release. Dr. Primus checked a box marked "Yes" in response to the question of whether appellant's injury was employment related. However, the reported date of injury was noted as September 20, 2011, which corresponds to appellant's prior left knee injury.

By decision dated January 21, 2015, OWCP's hearing representative affirmed OWCP's May 5, 2014 denial of appellant's claim. He found the reports of Drs. Sterk, DeBartolo, and Primus insufficient to establish causal relationship between appellant's diagnosed conditions and the March 18, 2014 employment incident.

LEGAL PRECEDENT

A claimant seeking benefits under FECA has the burden of establishing the essential elements of his or her claim by the weight of the reliable, probative, and substantial evidence, including that an injury was sustained in the performance of duty as alleged and that any specific condition or disability claimed is causally related to the employment injury.[5]

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. Generally, 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 occurred.[6] The second component is whether the employment incident caused a personal injury.[7] 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.[8]

Certain healthcare providers such as physician assistants, nurse practitioners, physical therapists, and social workers are not considered "physician[s]" as defined under FECA.[9] Consequently, their medical findings and/or opinions will not suffice for purposes of establishing entitlement to FECA benefits.[10]

---

[5] 20 C.F.R. § 10.115(e), (f); *see Jacquelyn L. Oliver*, 48 ECAB 232, 235-36 (1996).

[6] *Elaine Pendleton*, 40 ECAB 1143 (1989).

[7] *John J. Carlone*, 41 ECAB 354 (1989). Causal relationship is a medical question that generally requires rationalized medical opinion evidence to resolve the issue. *See Robert G. Morris*, 48 ECAB 238 (1996). A physician's opinion on whether there is a causal relationship between the diagnosed condition and the implicated employment factor(s) must be based on a complete factual and medical background. *Victor J. Woodhams*, 41 ECAB 345, 352 (1989). Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty, and must be supported by medical rationale, explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factor(s). *Id.*

[8] *Shirley A. Temple*, 48 ECAB 404, 407 (1997).

[9] 5 U.S.C. § 8101(2); 20 C.F.R. § 10.5(t).

[10] *K.W.*, 59 ECAB 271, 279 (2007); *David P. Sawchuk*, 57 ECAB 316, 320 n.11 (2006). A report from a physician assistant or certified nurse practitioner will not be considered medical evidence. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3a(1) (January 2013).

ANALYSIS

In its May 5, 2014 decision, OWCP accepted that the March 18, 2014 forklift incident occurred as alleged and that a medical condition of cervical strain had been diagnosed. However, it initially denied the claim because the evidence of record at the time was insufficient to establish that the diagnosed cervical strain was causally related to the accepted work event. Since the May 5, 2014 initial denial, OWCP received additional information regarding appellant's cervical strain, as well as medical evidence of trauma-induced left carpal tunnel syndrome, with surgical release on December 10, 2014. OWCP's hearing representative subsequently affirmed the denial of appellant's claim as the medical evidence was insufficient to establish a causal relationship between the March 18, 2014 forklift incident and appellant's diagnosed cervical strain and left carpal tunnel syndrome.

The Board finds that appellant failed to establish that her diagnosed left carpal tunnel syndrome was causally related to the March 18, 2014 forklift incident. Dr. Sterk, who examined appellant in the ER on March 18, 2014, did not report any left upper extremity symptoms. When Dr. DeBartolo initially examined appellant on March 24, 2014 she noted complaints of intermittent numbness in the right hand. She also reported pain radiating into the right shoulder and upper arm. At that time, appellant's associated symptoms included neck stiffness and right upper extremity paresthesia, particularly around her thumb and index finger. Dr. DeBartolo did not report any similar symptoms with respect to appellant's left upper extremity.

Approximately two months after the March 18, 2014 forklift incident, appellant advised her physical therapist that she was experiencing numbness in both hands, which she believed was carpal tunnel syndrome. The May 21, 2014 physical therapy treatment notes indicate that appellant reported that she recently started to feel "numbness" in her left upper extremity.

Dr. DeBartolo saw appellant for follow up on May 22, 2014, at which time she complained of constant numbness down her left arm into all fingers. She referred appellant for left upper extremity electrodiagnostic studies, which revealed evidence of left carpal tunnel syndrome. Dr. DeBartolo subsequently added left carpal tunnel syndrome to appellant's previously diagnosed employment-related cervical strain.

In a July 25, 2014 narrative report, Dr. DeBartolo indicated that on March 18, 2014 appellant was operating a forklift and was forcefully whipped sideways then forward, which caused a whiplash-type injury to her neck, shoulders, hands, and wrist. She also noted that when she first saw appellant on March 24, 2014 she "initially complained of neck and shoulder pain with numbness and tingling *down the left arm*." However, as previously noted, Dr. DeBartolo's March 24, 2014 treatment records did not document any left upper extremity complaints at the time. The reported complaints involved the right upper extremity.

In subsequent reports, Dr. DeBartolo continued to attribute appellant's left carpal tunnel syndrome to the March 18, 2014 forklift incident noting that "the forceful whiplash [and] axial loading" caused appellant's symptoms. She also continued to mischaracterize appellant's initial complaints as involving "numbness and tingling down the left arm."

Dr. DeBartolo mistakenly believed that appellant's left upper extremity complaints were contemporaneous with the March 18, 2014 forklift incident. The current record indicates a delayed onset of approximately six to eight weeks with respect to appellant's left upper extremity symptomology. While it is evident that Dr. DeBartolo believes appellant's carpal tunnel syndrome was traumatically induced, she has not provided an explanation for the delayed onset of left upper extremity symptoms. Consequently, her opinion is insufficient to establish causal relationship with respect to appellant's left carpal tunnel syndrome.

Dr. Primus' reports are similarly insufficient to establish causal relationship. He performed the December 10, 2014 left carpal tunnel release and indicated that appellant's condition was employment related. In one report, Dr. Primus identified March 18, 2014 as the date of injury, but did not otherwise describe how appellant was injured. In a December 26, 2014 work status report, he indicated that appellant's condition was employment related, but noted the date of injury as September 20, 2011. The reported date of injury was associated with appellant's left knee injury under claim number xxxxxx677.

A physician's opinion on causal relationship must be based on a complete factual and medical background and must be supported by medical rationale.[11] As discussed above, neither Dr. DeBartolo nor Dr. Primus provided a well-rationalized opinion regarding the cause of appellant's left carpal tunnel syndrome. Accordingly, the Board finds that the evidence of record fails to establish a causal relationship between the March 18, 2014 employment incident and appellant's diagnosed left carpal tunnel syndrome.

With respect to the claimed condition of cervical strain, the Board finds that the case is not in posture for decision. Dr. Sterk diagnosed neck strain when he examined appellant in the ER on March 18, 2014. At the time, he reported that appellant had been involved in a forklift incident and suffered a neck strain. When Dr. DeBartolo examined appellant six days later, she similarly diagnosed cervical strain. Her March 24, 2014 treatment notes identified March 18, 2014 as the date of injury. Dr. DeBartolo reported that appellant had been operating a forklift when the wheel fell off and the axle broke causing her to lose control of the machine and hit a guardrail. The March 24, 2014 treatment notes referenced a whiplash-type injury. Dr. DeBartolo also reported that appellant's x-rays revealed C3-C6 mild degenerative disc disease. She explained that appellant's complaints were most consistent with a cervical strain, which symptoms typically improved over the course of a few weeks with conservative treatment. In subsequent reports and treatment records, Dr. DeBartolo attributed appellant's condition to a whiplash-type injury and axial loading. She stated that appellant was forcefully whipped sideways then forward, and the jarring and impact caused her cervical complaints.

Proceedings under FECA are not adversarial in nature and OWCP is not a disinterested arbiter. The claimant has the burden to establish entitlement to compensation; however, OWCP shares responsibility in the development of the evidence to see that justice is done.[12] As noted, Dr. DeBartolo attributed appellant's cervical condition to a whiplash-type injury. While her various reports are insufficient to discharge appellant's burden of proving that the diagnosed

[11] *Victor J. Woodhams*, *supra* note 7.

[12] *William J. Cantrell*, 34 ECAB 1223 (1983).

cervical strain is causally related to the March 18, 2014 forklift incident, Dr. DeBartolo's opinion is sufficient to require further development of the case record by OWCP.[13]

Accordingly, the January 21, 2015 decision shall be set aside in part, and the case remanded to OWCP for further development. After such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

Appellant failed to establish that her left carpal tunnel syndrome and December 10, 2014 surgery are employment related. With respect to appellant's claimed cervical strain, that aspect of her claim is currently not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the January 21, 2015 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part. The case is remanded for further action consistent with this decision.

Issued: August 15, 2016
Washington, DC

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

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[13] *See John J. Carlone*, *supra* note 7; *Horace Langhorne*, 29 ECAB 820 (1978); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Initial Development of Claims*, Chapter 2.800.8b(3) (June 2011).