United States Department of Labor
Employees' Compensation Appeals Board

C.L., Appellant	)	
and	)	**Docket No. 16-1567**
	)	**Issued: May 19, 2017**
FEDERAL DEPOSIT INSURANCE CORPORATION, Chicago, IL, 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
COLLEEN DUFFY KIKO, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On July 27, 2016 appellant filed a timely appeal from a June 10, 2016 merit decision 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 met his burden of proof to establish additional conditions causally related to an October 21, 2011 employment injury.

[1] 5 U.S.C. § 8101 *et seq.*

[2] Appellant timely requested oral argument pursuant to section 501.5(b) of Board procedures. 20 C.F.R. § 501.5(b). By order dated December 19, 2016, the Board exercised its discretion and denied the request, finding that the arguments on appeal could adequately be addressed based on the case record. *Order Denying Request for Oral Argument,* Docket No. 16-1567 (issued December 19, 2016).

On appeal appellant asserts that the medical evidence is sufficient to establish that an employment-related October 21, 2011 motor vehicle accident caused lumbar disc disease, left flexor tendon rupture, and torn left knee medial meniscus. He further asserts that OWCP has never responded to his claims for compensation.

FACTUAL HISTORY

On November 1, 2011 appellant, then a 50-year-old bank regulator, filed a traumatic injury claim (Form CA-1) alleging that on October 21, 2011, while in travel status, he injured his wrist, left thumb, and hand, right fingers, left collar bone, right shoulder, neck, thoracic and lumbar spine, right knee, and right heel when his vehicle was struck from the rear with great force. He stopped work that day. An Illinois State Police Driver Information Exchange form indicates that an accident occurred on October 21, 2011. It provided the names and insurance information of two drivers, one of whom was appellant.

Aftercare instructions from MacNeal Hospital emergency department dated October 24, 2011 indicated that appellant was seen that day by a physician assistant. Discharge diagnoses were shoulder pain, knee pain, and foot pain.

In a February 29, 2012 attending physician's report (Form CA-20), Dr. George Tomecki, Board-certified in family medicine, noted a history of low back pain and strain and left thumb pain. He diagnosed back pain and sprain, and left thumb tendinitis. Dr. Tomecki checked a box marked "yes," indicating that the conditions were employment related, noting "motor vehicle collision -- trauma." He advised that appellant was unable to perform his full duties. Dr. Tomecki noted that he had referred appellant to Board-certified orthopedic surgeons Dr. Michael Zindrick for his spinal condition and Dr. Michael Bednar for his hand. He ordered a magnetic resonance imaging (MRI) scan of the lower back.

On March 22, 2012 OWCP accepted the condition of unspecified backache due to the October 21, 2011 employment injury. The acceptance letter explained in detail the procedures to be followed for obtaining authorization for medical expenses and for claiming compensation.

By letter dated May 25, 2012, appellant informed OWCP that he had transferred from the employing establishment to another independent federal agency, the Consumer Financial Protection Bureau (CFPB), also in Chicago, Illinois, effective April 22, 2012.[3]

In an attending physician's report dated March 11, 2013, Dr. Tomecki diagnosed a partial rupture of the flexor tendon of the left thumb at the wrist intersection. He again indicated by checking a box marked "yes" that the condition was employment related, stating "traumatic injury," and noting that appellant presented to an emergency room within 72 hours and to his office within one week and had been referred to Dr. Bednar. Dr. Tomecki advised that the thumb tendon injury had been substantially corrected by surgery in May 2012, but that a concurrent spine injury and a resulting knee injury appeared to be permanent and involved

[3] In letters dated February 21, April 26, and August 2, 2012, OWCP asked appellant if an action was being pursued against a third party. There is no indication in the record before the Board that he responded to these inquiries.

ongoing disability. In a similar attending physician's report also dated March 11, 2013, Dr. Tomecki diagnosed a leftward disc protrusion at L4-5 with radiculopathy and right paracentral disc protrusion at L5-S1 with annular tear. He noted that appellant had been referred to Dr. Zindrick.

In a June 7, 2013 letter, appellant stated that his knee injury became apparent on November 8, 2012 and resulted from changes in body motion and walking as a result of his October 21, 2011 employment spine injury. He forwarded a May 31, 2013 attending physician's report from the office of Dr. Michael Hejna, a Board-certified orthopedic surgeon. It noted that appellant had reported a traumatic spinal injury and resulting stress on the knee which became more serious in November 2012 with pain and swelling. A medial meniscus tear was diagnosed, and a box on the form was checked "yes," indicating that the condition was employment related. Dr. Hejna noted that appellant reported "traumatic spine injury and resulting new stress on knee." An MRI scan was prescribed and surgery recommended.[4]

OWCP, on November 1, 2013, informed appellant of the evidence needed to establish additional and/or consequential conditions related to the accepted October 21, 2011 work injury. It specifically informed him that his treating physician should provide a complete history of the October 21, 2011 work injury, including any similar problems which may have preexisted the condition for which he was treated and which he was now claiming to have materially changed or worsened due to the automobile accident. The physician was also asked to provide a detailed description of the development of any newly-diagnosed condition with a reasoned medical opinion as to how any additional diagnoses were a result of the October 21, 2011 work injury or to the accepted conditions.

In a letter dated November 13, 2013, appellant maintained that his lumbar disc degeneration, left thumb and wrist tendon damage, and torn medial meniscus of the left knee were related to the October 21, 2011 employment injury.

In a report dated July 30, 2014, Dr. James P. Elmes, a Board-certified orthopedic surgeon, noted a history that appellant was injured in a motor vehicle accident on October 21, 2011. He noted medical evidence reviewed,[5] described appellant's complaint of low back, left knee, and left wrist pain, and his report that low back pain began on the date of injury and persisted to the present time. Dr. Elmes noted that appellant had an onset of left knee pain in November 2012 which he felt was due to an altered gait caused by the low back injury. He noted a past history of a fracture of the left radius in 2003, which had been surgically repaired.

[4] On March 1, 2013 appellant submitted a leave buy-back (LBB) application for 187 hours of sick leave for intermittent hours from October 24, 2011 to March 1, 2013. On March 6, 2013 OWCP informed him that it could not process the LBB application as the employing establishment had not completed its portion of the application. On June 27, 2013 the employing establishment forwarded an amended LBB application which included 71 hours of compensation claimed from March 15 to May 4, 2013. It indicated that, for the period of LBB claimed, appellant was employed by CFPB and, therefore, it could not verify the leave claimed. The form further indicated that appellant used continuation of pay (COP) for four hours on October 24, 2011, four hours on October 28, 2011, with no other lost time during the COP period, October 24 to December 7, 2011. CFPB certified the 71 hours claimed on September 19, 2013.

[5] This included a number of reports not found in the case record before the Board.

Appellant had additional left arm surgery on February 6, 2012 to repair the flexor tendon of the left thumb with removal of bone plate from the healed left radius fracture. Left arm examination revealed diminished grip strength, normal fine and gross motor coordination, no measurable atrophy, and decreased vibratory, light touch, and pinprick sensation. The left wrist had full range of motion with mild tenderness over a well-healed scar from previous surgery. There was some mild left thenar tenderness and tenderness over the interphalangeal joint and fingertip of the left index finger. No instability was noted.

Dr. Elmes' July 29, 2014 examination demonstrated a normal gait with complaints of low back, left knee, and right posterior thigh pain with walking, and left knee pain when squatting. Left thigh sensation was decreased to light touch and pinprick, and left medial foot to pinprick only. Left knee examination demonstrated tenderness and episodic medial patellar crepitus, with no effusion or quadriceps atrophy, and good stability. Lumbar spine examination demonstrated midline tenderness at L5-S1 with no sacroiliac tenderness and decreased lumbar range of motion.

Dr. Elmes found no evidence of symptom magnification. He described appellant's report that back pain limited sitting to 20 minutes continually after which he had to stand for 5 to 10 minutes for relief, that he could only drive 20 minutes at a time, that lifting, climbing stairs, repetitive bending, twisting, stooping, and squatting aggravated back and knee pain, and that he could only shop for 20 to 30 minutes at a time. Dr. Elmes diagnosed status post two years, five months repair of partially torn flexor tendon left thumb with residual pain, multilevel lumbar degenerative disc disease, multilevel disc protrusion, and foraminal stenosis with persistent low back pain, and torn left medial meniscus. Appellant related that Dr. Bednar, who performed the wrist surgery, advised that fraying of the flexor tendon was due to rubbing on the fixation plate for the healed radial fracture. He reported that he had no low back pain or left knee pain before the October 21, 2011 work injury. Dr. Elmes concluded that there was no spasm, atrophy, or neurological deficit noted on his examination, that a lumbar spine MRI scan showed multilevel degenerative disc disease with multilevel disc protrusion and multilevel spinal stenosis which were normal degenerative changes for appellant's age, that an MRI scan of the knee was positive for torn medial meniscus posterior horn and body of the meniscus, which could be due to an altered gait pattern caused by spine pain or could be an aggravation of a preexisting degenerative tear.

By letter dated March 3, 2015, OWCP accepted additional conditions of sprain of back, lumbar region, and sprain of wrist, interphalangeal, left. In a second March 3, 2015 letter, it noted that Dr. Elmes had referred to medical evidence which had not been provided to OWCP for review. OWCP indicated that, to determine if additional conditions should be accepted, appellant should provide a copy of records of all medical treatment provided since the date of the work injury on October 21, 2011. It further noted that Dr. Elmes had not provided an explanation as to how the October 21, 2011 work injury contributed to the diagnosed tendon tear of the left thumb and advised appellant that Dr. Elmes should provide an additional report in which he explained whether or not this was caused or aggravated by the October 21, 2011 work injury.

On May 28, 2015 Dr. Elmes noted that he had reviewed his previous report, and that appellant had the same complaints of low back, left knee, and left wrist pain as when seen on July 29, 2014. Physical examination on May 28, 2015 revealed no limp and a normal walking

heel-to-toe gait pattern. Left arm strength testing on dynamometer was diminished. There was tenderness to examination of the left knee with decreased left leg strength and no measurable atrophy in bilateral extremities. Dr. Elmes diagnosed back strain with persistent backache and associated multilevel degenerative disc disease, multilevel protrusion, and foraminal stenosis, torn left medial meniscus with residual pain, and status post repair of partially torn flexor tendon left thumb with residual pain. He advised that appellant had no left knee complaints prior to the October 21, 2011 work injury and that left knee pain began in November 2012 and continued. Dr. Elmes opined that, since appellant had no low back complaints before the work injury, when his back pain began and had continued to present, and because he had no wrist pain before the motor vehicle accident, his lumbar and thumb/wrist conditions were causally related to the employment injury.

An October 24, 2011 x-ray of the right heel, submitted to OWCP on July 20, 2015, revealed no acute findings.

In a November 30, 2015 decision, OWCP declined to accept additional conditions caused by the October 21, 2011 work injury. It noted that the medical evidence was insufficient to support expansion of the claim because there was no detailed medical opinion evidence supporting these additional conditions were caused by the October 21, 2011 work injury.

Appellant timely requested a hearing with a representative of OWCP's Branch of Hearings and Review.[6] He submitted Office of Personnel Management documentation indicating that disability retirement had been approved for the condition of disc protrusion with annular tear and radiculopathy.

On April 18, 2016 appellant submitted a March 26, 2012 MRI scan of the lumbar spine that demonstrated spondylotic changes, disc protrusions at L2-3, L3-4, and L4-5 with moderate foraminal narrowing, and a disc protrusion at L5-S1 with annual tear and moderate foraminal narrowing which could be causing bilateral S1 radiculopathy.

On April 18, 2016 OWCP received an October 28, 2013 report from Dr. Zindrick. Dr. Zindrick noted appellant's complaint of radiating low back pain that began after an October 21, 2011 motor vehicle accident when appellant's car was rear-ended. The back pain was continual and radiated into his legs. Dr. Zindrick described lumbar MRI scan findings and advised that back examination demonstrated painful range of motion, no spasm, and minimal tenderness to percussion. Appellant could heel walk with no weakness, and had good quadriceps strength bilaterally. Sensation was intact to pinprick and light touch throughout bilateral legs, and Babinski's and clonus were negative. Straight leg raising was negative to 90 degrees. Dr. Zindrick diagnosed documented disc degeneration at multiple levels with multiple level disc protrusions that had been symptomatic since an October 21, 2011 motor vehicle accident and had been unresponsive to conservative care. He advised that appellant was unable to work due to sitting requirements of his job.

[6] Alan J. Shapiro, Esquire, began representing appellant on March 22, 2013. On March 10, 2016 he notified OWCP that he was no longer representing appellant.

At the hearing, held on April 14, 2016, appellant testified that he had retired on disability in June 2015 and that he wanted OWCP to accept additional conditions and grant FECA compensation. The hearing representative discussed the lack of medical evidence in the record, noting that it did not include the emergency department report from October 24, 2011, the scan report of the knee, an operative report regarding the tendon surgery, and treatment notes from physicians. He further noted the lack of specific information regarding the motor vehicle accident and urged appellant to submit additional evidence. The record was held open for 30 days. Nothing further was submitted.

By decision dated June 10, 2016, OWCP's hearing representative affirmed the November 30, 2015 decision, finding the medical evidence insufficient to accept additional medical conditions caused by the October 21, 2011 work injury. The hearing representative discussed the evidence of record and observed that details as to how appellant was injured in the accident were lacking, noting that appellant had not provided a sufficient explanation to convey an understanding of the accident and his claimed injuries.

LEGAL PRECEDENT

The general rule respecting consequential injuries is that, when the primary injury is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury is deemed to arise out of employment unless it is the result of an independent intervening cause, which is attributable to the employee's own intentional conduct. The subsequent injury is compensable if it is the direct and natural result of a compensable injury. With respect to consequential injuries, the Board has held that, where an injury is sustained as a result of an impairment residual to an employment injury, the new or second injury, even though not employment related, is deemed because of the chain of causation, to arise out of and in the course of employment.[7]

An employee has the burden of proof to establish that any specific condition for which compensation is claimed is causally related to the employment injury.[8] Causal relationship is a medical issue, and the medical evidence required to establish a causal relationship is rationalized medical evidence.[9] The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the employee.[10] Neither the mere fact that a disease or condition manifests itself during a period of employment nor the belief that the disease or condition was caused or aggravated by employment factors or incidents is sufficient to establish causal relationship.[11]

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

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

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

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

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

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish that his current lumbar condition, left thumb/wrist tendon tear, or left medial meniscus tear were caused or aggravated by, or were a consequence of the accepted motor vehicle accident that occurred on October 21, 2011. OWCP accepted backache, unspecified, sprain of back, lumbar region, and sprain of wrist, interphalangeal on the left due to the October 21, 2011 employment injury.

The opinion of a physician supporting causal relationship must be based on a complete factual and medical background supported by affirmative evidence, must address the specific factual and medical evidence of record, and must provide medical rationale explaining the nature of the relationship between the diagnosed condition and the established incident or factor of employment.[12] No physician did so in this case.

The Board initially notes that the record contains very little documentation regarding the October 21, 2011 motor vehicle accident. The only evidence of record is an exchange of information form that merely lists the drivers involved. The form does not contain a description of the accident. Therefore, the Board cannot ascertain the degree of severity of the October 21, 2011 injury which would provide a basis for review of the accuracy, probative value, or relevancy of the medical evidence presented.[13]

The record indicates that following the injury appellant missed only a half day of work on October 24, 2011, the day he visited MacNeal Hospital emergency department and an additional four hours on October 28, 2011.[14] The only medical evidence regarding the emergency department visit consists of aftercare instructions which indicate that he was seen by a physician assistant. This does not constitute medical evidence as a physician assistant is not considered a physician under FECA.[15]

The March 26, 2012 lumbar spine MRI scan did not provide a cause of any diagnosed conditions, and medical evidence which does not offer any opinion regarding the cause of an employee's condition is of limited probative value on the issue of causal relationship.[16] Moreover, when diagnostic testing is delayed, uncertainty mounts regarding the cause of the diagnosed condition and a question arises as to whether that testing in fact documents the injury claimed by the employee. The greater the delay in testing, the greater the likelihood that an event not related to employment has caused or worsened the condition for which the employee

[12] *Robert Broome*, 55 ECAB 339 (2004).

[13] *L.G.*, Docket No. 09-1692 (issued August 11, 2010) (to be of probative value a medical opinion must be based on a complete and accurate factual and medical background. Medical opinions based on an incomplete or inaccurate history are of diminished probative value).

[14] *Supra* note 4.

[15] *Ricky S. Storms*, 52 ECAB 349 (2001). Section 8101(2) defines the term "physician" to include 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).

[16] *Willie M. Miller*, 53 ECAB 697 (2002).

seeks compensation.[17] The MRI scan was not completed until March 26, 2012, five months after the October 21, 2011 employment injury.

The first treating physician's report submitted after the October 21, 2011 employment injury was Dr. Tomecki's attending physician's report dated February 29, 2012, more than four months after the work injury. In that report, while the physician checked a box marked "yes," indicating that the diagnoses of back pain and sprain and left thumb tendinitis were employment related, he merely noted "motor vehicle collision -- trauma." In two March 11, 2013 attending physician's reports, Dr. Tomecki further diagnosed a partial rupture of the flexor tendon of the left thumb at wrist intersection and a leftward disc protrusion at L4-5 with radiculopathy, and right paracentral disc protrusion at L5-S1 with annular tear. He again indicated by checking a box marked "yes" that the diagnosed conditions were employment related, stating "traumatic injury." Dr. Tomecki advised that appellant was seen in his office within one week of the employment injury. The record, however, contains no additional evidence from Dr. Tomecki. Medical form reports merely asserting causal relationship cannot discharge appellant's burden of proof.[18] The Board has long held that when a physician's opinion on causal relationship consists only of checking "yes" to a form question, without explanation or rationale, that opinion is of diminished probative value and is insufficient to establish a claim.[19] To establish causal relationship, a claimant must submit a physician's report in which the physician reviews the employment factors identified as causing the claimed condition and, taking these factors into consideration as well as findings upon examination, states whether the employment injury caused or aggravated the diagnosed conditions and presents medical rationale in support of his or her opinion.[20] Dr. Tomecki submitted no rationalized medical evidence explaining the mechanics of how the October 21, 2011 motor vehicle accident caused or aggravated the diagnosed conditions.[21] His opinion is, therefore, insufficient to establish additional accepted conditions.

As to Dr. Elmes' opinion, in his July 30, 2014 report, he diagnosed status post repair of partially torn flexor tendon left thumb with residual pain, multilevel lumbar degenerative disc disease, multilevel disc protrusions, and foraminal stenosis with persistent low back pain, and torn left medial meniscus. While he noted appellant's report that Dr. Bednar, who performed the wrist surgery, told him that fraying of the flexor tendon was due to it rubbing on the fixation plate for the healed radial fracture, Dr. Elmes himself did not provide an opinion on the cause of appellant's left wrist condition or link it to the October 21, 2011 work injury.[22] Regarding appellant's low back, he noted that appellant had no back pain prior to the October 21, 2011 work injury. Dr. Elmes' July 29, 2014 back examination demonstrated no spasm, atrophy, or

[17] *Mary A. Ceglia*, 55 ECAB 626 (2004).

[18] *Id.*

[19] *Sedi L. Graham*, 57 ECAB 494 (2006).

[20] *D.E.*, 58 ECAB 448 (2007).

[21] *See J.M.*, Docket No. 15-1906 (issued January 7, 2016).

[22] *Supra* note 16.

neurological deficit found. He then described the lumbar spine MRI scan findings which, he opined, were normal degenerative changes for appellant's age.

Regarding the left knee, Dr. Elmes referenced MRI scan findings of a torn medial meniscus and advised that this could be due to an altered gait pattern caused by spine pain or could be an aggravation of a preexisting degenerative tear. The MRI scan, however, is not found in the case record before the Board.

On May 28, 2015 Dr. Elmes diagnosed back strain with persistent backache and associated multilevel degenerative disc disease, multilevel protrusion, and foraminal stenosis, torn left medial meniscus with residual pain, and status post repair of partially torn flexor tendon left thumb with residual pain. He advised that appellant had no left knee complaints before the October 21, 2011 work injury and that left knee pain began in November 2012 and continued. Dr. Elmes advised that, since appellant had no low back complaints prior to the employment injury, when his back pain began and had continued to present, and because he had no wrist pain prior to the motor vehicle accident, his lumbar and thumb/wrist conditions were causally related to the employment injury. An opinion that a condition is causally related because the employee was asymptomatic before the injury is insufficient, without sufficient rationale, to establish causal relationship.[23] Neither report from Dr. Elmes, which are somewhat contradictory, contains sufficient rationale explaining how the October 21, 2011 work injury caused or aggravated the diagnosed conditions. His reports, therefore, are of insufficient rationale to meet appellant's burden of proof.

Dr. Zindrick's October 28, 2013 report is also insufficient to meet appellant's burden of proof. He reported that appellant had continuous back pain following an October 21, 2011 motor vehicle accident. While Dr. Zindrick diagnosed disc degeneration at multiple levels with multiple level disc protrusions that had been symptomatic since an October 21, 2011 motor vehicle accident, he did not explain in any way how this accident, which occurred two years previously, caused or aggravated the diagnosed condition.

The May 31, 2013 report from Dr. Hejna's office is signed by a physician assistant with an illegible signature. As noted above, a physician assistant is not considered a physician under FECA.[24] Moreover, medical reports lacking proper identification cannot be considered as probative evidence in support of a claim.[25]

Rationalized medical evidence is evidence which relates a work incident or factors of employment to a claimant's condition, with stated reasons of a physician. The opinion must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship of the diagnosed condition and the specific employment factors or employment injury.[26] The Board finds that appellant has not submitted sufficient rationalized

[23] *Michael S. Mina*, 57 ECAB 379 (2006).

[24] *Ricky S. Storms, supra* note 15.

[25] *D.D.*, 57 ECAB 734 (2006).

[26] *C.O.*, Docket No. 10-0189 (issued July 15, 2010).

medical evidence supporting a causal relationship between any of the claimed additional conditions and the October 21, 2011 employment injury.[27]

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 did not meet his burden of proof to establish that additional conditions were causally related to an October 21, 2011 employment injury.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated June 10, 2016 is affirmed.

Issued: May 19, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

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

[27] As to appellant's assertion that he is entitled to wage-loss compensation or LBB, *supra* note 5, the Board's jurisdiction is limited to review of final OWCP decisions issued within 180 days from the filing of the appeal. 20 C.F.R. § 501.3(e); *see J.B.*, Docket No. 09-2191 (issued May 14, 2010). The record does not contain a final adverse OWCP decision on this matter within the Board's jurisdiction. *See* 20 C.F.R. § 501.2(c).