United States Department of Labor
Employees' Compensation Appeals Board

S.N., Appellant	)	
and	)	**Docket No. 18-1627**
	)	**Issued: May 15, 2019**
DEPARTMENT OF VETERANS AFFAIRS, HUNTER HOLMES MCGUIRE HOSPITAL, Richmond, VA, 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:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On August 27, 2018 appellant, through counsel, filed a timely appeal from a July 13, 2018 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 medical conditions causally related to the accepted September 28, 2016 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 September 30, 2016 appellant, then a 46-year-old nurse, filed a traumatic injury claim (Form CA-1) alleging that she sustained an injury on September 28, 2016 when she slipped and fell in a puddle of water while in the performance of duty. She noted that her right leg had split before she landed on the floor. Appellant claimed injury to her left leg, left knee, right shoulder, and back as well as a headache.

In a September 28, 2016 emergency department report, Dr. James R. Freeman, a nephrologist Board-certified in internal medicine, noted that appellant reported slipping and falling on water at work approximately 10 minutes prior. Appellant also noted that her legs did a split and that she had hit her head on the wall. She complained of posterior neck and upper back pain radiating to her right shoulder and bowel incontinence at time of injury. Appellant denied loss of consciousness or loss of urinary control. She indicated that she was undergoing physical therapy for a prior shoulder injury. X-rays did not demonstrate acute abnormalities of the cervical spine or right shoulder, but revealed mild degenerative changes of the cervical spine and mild osteoarthritis of the acromioclavicular joint. Appellant was provided a cervical collar and prescribed Valium for muscle spasms/tremors.

In a September 30, 2016 employee health report, Dr. Sara Mears, Board-certified in internal medicine and pediatrics, noted that appellant was seen following her September 28, 2016 emergency room visit. The history of injury was noted as a slip and fall on a puddle of water in the main hallway of the employing establishment. Appellant indicated that she fell against the wall and her legs split. She also noted undergoing physical therapy for her right shoulder. Dr. Mears noted examination findings and diagnosed "fall with injury as stated." In an October 3, 2016 note, she excused appellant from work for the period September 29 through October 13, 2016.

In an October 12, 2016 letter, the employing establishment controverted the claim, alleging that there were discrepancies regarding how the injury occurred and that the medical documentation was deficient. It noted that appellant was receiving physical therapy for a preexisting shoulder condition at the time of the claimed incident.

In a development letter dated October 17, 2016, OWCP advised appellant that the evidence received to date was insufficient to establish her claim. It informed her of the type of factual and medical evidence necessary to establish her claim and provided a questionnaire for her to complete. OWCP afforded appellant 30 days to submit further evidence.

In an October 18, 2016 letter, the employing establishment continued to controvert the claim. It alleged that there were inconsistencies as to how the injury occurred and the medical evidence did not establish causal relationship.

OWCP subsequently received appellant's October 24, 2016 response to its questions along with copies of a September 28, 2016 right shoulder x-ray and computerized tomography (CT) head and cervical spine reports, findings from which Dr. Freeman previously noted.

In an October 3, 2016 report, Dr. Mears reiterated the history of the September 28, 2016 work injury. She noted that appellant reported that her left leg went out from under her and that she landed on her left knee, then hit her upper back/neck, and right shoulder. Dr. Mears noted that

the emergency department CT scans of the head and neck and the right shoulder x-ray were all negative for acute findings. She reported significant muscle spasms on examination. Dr. Mears indicated that the fall resulted in an acute flare up of appellant's chronic neck and back pain. She noted that there were no neurologic deficits on examination, although appellant had chronic issues with urinary urge incontinence. In an October 13, 2016 employing establishment work capacity evaluation form, Dr. Mears provided restrictions, but indicated that appellant was temporarily totally disabled for the period September 28 through November 10, 2016.

By decision dated November 18, 2016, OWCP denied appellant's claim. It found that the evidence submitted established that the September 28, 2016 incident occurred, as alleged, but the medical evidence submitted was insufficient to establish that a medical condition was diagnosed in connection with the employment incident. Thus, OWCP concluded, that the requirements had not been met to establish an injury as defined by FECA.

OWCP subsequently received additional evidence. In a November 21, 2016 report, Dr. Marion Herring, an orthopedic surgeon, noted that appellant was seen on October 31, 2016 for a work-related injury to her right shoulder which she sustained on September 28, 2016 during a slip and fall. He reported that a November 15, 2016 magnetic resonance imaging (MRI) scan of the right shoulder revealed supraspinatus tendinopathy and a full-thickness nonretracted tear, mild infraspinatus and long head of the biceps tendinopathy, mild glenohumeral osteoarthritis, and moderate acromioclavicular joint degenerative changes. Dr. Herring noted that appellant was working full duty. He provided examination findings and an impression of sprain of the right rotator cuff capsule. Surgical options for the right shoulder were discussed, but appellant preferred to postpone surgery until she retired in April 2017.

On December 8, 2016 appellant requested a review of the written record before an OWCP hearing representative. She also submitted additional evidence.

In an October 4, 2016 report, Dr. Douglas Okay, a Board-certified family practitioner, noted that appellant was injured on September 28, 2016 when she slipped and fell on a wet spot and injured her upper back, shoulder, and knee. Appellant noted that she currently was in physical therapy for a frozen shoulder. Dr. Okay indicated that the lumbar examination was essentially normal with lumbosacral tenderness noted on both sides of the paraspinal area. Sensory examination was also normal in both the left and right lower extremity. The lumbar spine x-ray revealed L4-5 and L5-S1 degenerative disc disease and L3-4 anterolisthesis, but no acute findings. Dr. Okay diagnosed degenerative disc disease of the lumbar spine and lumbosacral spondylolisthesis.

In an October 31, 2016 report, Dr. Herring noted that the x-rays of appellant's right shoulder and cervical spine, as well at the CT of her head on the date of injury did not show abnormalities. He reported that she felt that the injury exacerbated her prior shoulder condition. Dr. Herring also reported that appellant had not been in recent treatment for the left knee, but that she indicated that she had a lot of bruising and had pain from the muscle pull in her left thigh. Appellant reported that her knee was improving. Dr. Herring reported examination findings and took x-rays of her right shoulder and left knee. The right shoulder x-ray showed type 2 acromial spur and the left knee x-ray showed bilateral spurring of lateral patella. Dr. Herring diagnosed sprain of right rotator cuff capsule and left patellofemoral syndrome. He also reported that appellant had left knee osteoarthritis. Dr. Herring referred her for a right shoulder MRI scan.

Diagnostic tests from November 15, 2016 were also submitted. The MRI scan of the lumbar spine indicated disc herniations at L3-4, L4-5, and L5-6 with right L3, left L4, and bilateral L5 nerve impingement. The MRI scan of the cervical spine indicated multilevel spondylosis of the cervical spine with disc protrusions at C2-3, C3-4, and C4-5 abutting the ventral cord with no nerve root compression, no acute fracture or subluxation or destructive bone lesion. The MRI scan of the right joint of the upper extremity indicated supraspinatus tendinopathy and a full-thickness nonretracted tear, mild infraspinatus and long head of the biceps tendinopathy, mild glenohumeral osteoarthritis, and moderate acromioclavicular joint degenerative changes.

In a November 18, 2016 report, Dr. Warren B. Kirby, a Board-certified physiatrist, noted that appellant had lumbar and cervical radicular symptoms associated with spondylosis, which were complicated by morbid obesity. He noted that she indicated that the symptoms were related to a workers' compensation injury that occurred on September 28, 2016. Dr. Kirby provided examination findings and noted the results of the cervical and lumbar spine MRI scans. He diagnosed cervical spondylosis with radiculopathy, lumbar spondylosis with radiculopathy, and morbid obesity. Additional upper extremity diagnostic testing was ordered.

In a December 19, 2016 report, Dr. Herring noted that examination of appellant's right shoulder revealed subacromial crepitation, external rotation and supraspinatus strength 4/5 with positive Hawkins, Neer impingement, and Jobe's tests. He also discussed her November 15, 2016 MRI scan of the right shoulder. Dr. Herring diagnosed right rotator cuff capsule sprain.

In a January 5, 2017 report, Dr. Kirby provided examination findings and discussed the results of nerve conduction velocity studies of the bilateral upper extremities and an electromyogram of the right upper extremity and cervical paraspinals. The electrodiagnostic testing revealed mild bilateral median neuropathy at the wrist, consistent with prior successful carpal tunnel releases with no evidence of active cervical radiculopathy. Dr. Kirby diagnosed right and left median neuropathy, right shoulder pain, cervicalgia, and lumbar spondylosis with radiculopathy. He opined that appellant's shoulder issues were the main reason for her upper extremity complaints.

By decision dated July 13, 2018, an OWCP hearing representative modified the prior decision to find that the factual and medical components of fact of injury had been established. However, she denied the claim, finding that the medical evidence of record failed to include a rationalized opinion which explained how the diagnosed conditions were causally related to the accepted September 28, 2016 employment incident.

LEGAL PRECEDENT

An employee seeking benefits under FECA has the burden of proof to establish the essential elements of his or her claim, including the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was timely filed within the applicable time limitation period of FECA,[3] that an injury was sustained in the performance of duty as alleged, and that any disability or medical condition for which compensation is claimed is causally related

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

to the employment injury.[4] These are the essential elements of each and every compensation claim, regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[5] To 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]

Causal relationship is a medical question that requires rationalized medical opinion evidence to resolve.[9] A physician's opinion on whether there is causal relationship between the diagnosed condition and the implicated employment incident must be based on a complete factual and medical background.[10] 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 an employment incident.[11]

In a 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.[12]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish medical conditions causally related to the accepted September 28, 2016 employment incident.

Appellant was initially treated by Dr. Freeman and Dr. Mears following the September 28, 2016 employment incident. While both physicians noted the history of the September 28, 2016 employment incident, neither physician provided a firm medical diagnosis. Dr. Freeman did not

---

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

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

[6] *See T.O.*, Docket No. 18-1012 (issued October 29, 2018); *Elaine Pendleton*, 40 ECAB 1143 (1989).

[7] *See T.O., id.*; *John J. Carlone*, 41 ECAB 354 (1989).

[8] *See K.C.*, Docket No. 17-1693 (issued October 29, 2018); *Shirley A. Temple*, 48 ECAB 404, 407 (1997).

[9] *See K.C., id.; Robert G. Morris*, 48 ECAB 238 (1996).

[10] *See K.C., supra* note 8; *Victor J. Woodhams*, 41 ECAB 345, 352 (1989).

[11] *Id.*

[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Causal Relationship*, Chapter 2.805.3e (January 2013).

diagnose a medical condition in connection to the accepted employment incident. In her September 30, 2016 report, Dr. Mears assessed a fall with injury, but also failed to diagnose a medical condition. In her October 3, 2016 report, she indicated that the fall resulted in an acute flare up of appellant's chronic neck and back pain. The Board has consistently held that pain is a symptom, not a compensable medical diagnosis.[13] Therefore these medical reports are insufficient to establish appellant's claim.

Dr. Kirby noted that appellant had a work-related injury to which she attributed her symptoms. In his November 18, 2016 and January 6, 2017 reports, he diagnosed cervical spondylosis with radiculopathy, lumbar spondylosis with radiculopathy, right and left median neuropathy, right shoulder pain, and cervicalgia. However, Dr. Kirby did not provide an opinion regarding the cause of the diagnosed conditions. 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] These reports, therefore, are insufficient to establish appellant's claim.

The reports from Dr. Herring and Dr. Okay are also insufficient to establish appellant's claim. Dr. Herring diagnosed sprain of right rotator cuff capsule and left patellofemoral syndrome and indicated that it was a work-related injury. Dr. Okay diagnosed degenerative disc disease lumbar spine and lumbosacral spondylolisthesis and noted that she had a work-related injury. While Drs. Herring and Okay provided an accurate history of injury and firm medical diagnoses in their respective reports, they each offered a conclusory statement on causal relationship and are therefore of limited probative value.[15] Without explaining how, physiologically, the employment incident caused or contributed to the diagnosed conditions, their opinion on causal relationship are insufficiently rationalized and of limited probative value.[16] Such medical rationale is necessary in this case as appellant's medical findings reveal that she had chronic medical conditions prior to her work injury and no physician distinguished between the effects of her preexisting conditions and her work injury.[17]

The record also includes diagnostic reports. Diagnostic testing reports lack probative value as they do not provide an opinion regarding the cause of the diagnosed conditions.[18]

The Board finds that because appellant has not submitted reasoned medical evidence establishing a medical condition causally related to her accepted employment incident, she has not met her burden of proof.

[13] *See B.B.*, Docket No. 18-1036 (issued December 31, 2018); *C.F.*, Docket No. 08-1102 (issued October 10, 2008).

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

[15] *See B.B.*, Docket No. 18-1036 (issued December 31, 2018); *B.W.*, Docket No. 16-1012 (issued October 21, 2016); *see also T.H.*, 59 ECAB 388 (2008).

[16] *See L.M.*, Docket No. 14-0973 (issued August 25, 2014); *R.G.*, Docket No. 14-0113 (issued April 25, 2014); *K.M.*, Docket No. 13-1459 (issued December 5, 2013); *A.J.*, Docket No. 12-0548 (issued November 16, 2012).

[17] *See S.D.*, Docket No. 16-0999 (issued October 16, 2017).

[18] *S.H.*, Docket No. 17-1447 (issued January 11, 2018).

On appeal counsel contends that OWCP's July 13, 2018 decision is contrary to fact and law. For the reasons set forth above, the Board finds that appellant 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 medical conditions causally related to the accepted September 28, 2016 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the July 13, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 15, 2019
Washington, DC

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

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

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