United States Department of Labor
Employees' Compensation Appeals Board

W.L., Appellant	)	
and	)	**Docket No. 20-1589**
	)	**Issued: August 26, 2021**
DEPARTMENT OF THE AIR FORCE, U.S. AIR FORCES IN EUROPE, ROYAL AIR FORCE BASEMILDENHALL, England, 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:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On September 4, 2020 appellant, through counsel, filed a timely appeal from a July 17, 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.[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 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 Board notes that, following the July 17, 2020 decision, appellant submitted additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant has met her burden of proof to establish a left wrist condition causally related to the accepted May 11, 2016 employment incident.

FACTUAL HISTORY

This case has previously been before the Board.[4] The facts and circumstances as set forth in the Board's prior decision are incorporated herein by reference. The relevant facts are as follows.

On June 15, 2016 appellant, then a 42-year-old lead child development program technician, filed a traumatic injury claim (Form CA-1), alleging that on May 11, 2016 a child punched her on her left wrist through a wrist splint she was wearing due to a prior injury while in the performance of duty.[5] OWCP assigned OWCP File No. xxxxxx798. Appellant stopped work on May 11, 2016.

In a development letter dated June 28, 2016, OWCP advised appellant of the deficiencies of her claim. It specifically noted that there was no diagnosis of any condition resulting from the alleged injury. OWCP requested additional factual and medical evidence from appellant, and provided a questionnaire for her completion. It afforded her 30 days to respond.

In response to OWCP's development letter, appellant submitted additional evidence. On June 6, 2016 Jamie L. Meyer, a physician assistant, excused appellant from work until June 27, 2016 and then returned her to light duty. Appellant submitted the job description for an education technician (child development).

In a work/school excuse form dated June 27, 2016, Dr. Alan C. Puddy, a Board-certified orthopedic surgeon, recommended light duty for one month. In a memorandum dated July 21, 2016, he treated appellant for a left wrist injury sustained while at work. Similarly, in a report dated July 21, 2016, Dr. Puddy noted that she experienced a twisting injury to her left wrist on April 11, 2016 while moving a water table. Appellant reported that the ulnar-sided left wrist pain started to subside when a child struck her on the left wrist while in the performance of duty. Examination findings of the left upper extremity revealed positive fovea sign, tenderness overlying the ulnocarpal joint, and limited range of motion. Dr. Puddy noted a magnetic resonance imaging (MRI) scan arthrogram of the left wrist revealed a traumatic triangular fibrocartilaginous complex (TFCC) tear, distal radioulnar joint marrow edema, and irregularity consistent with ulnar impaction syndrome. He found the tears consistent with wrist trauma.

By decision dated August 3, 2016, OWCP denied appellant's May 11, 2016 traumatic injury claim, finding that the medical evidence of record was insufficient to establish a medical condition causally related to the accepted employment incident.

An x-ray dated May 17, 2016 revealed positive ulnar variance. On July 19, 2016 appellant underwent a left wrist MRI scan arthrogram, which revealed ulnar impaction syndrome, TFCC

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[4] Docket No. 19-0396 (issued May 18, 2020).

[5] OWCP had previously accepted that appellant had sustained a left wrist sprain on April 11, 2016 when emptying a water table into a sink while in the performance of duty. It assigned OWCP File No. xxxxxx799.

sprain, high grade partial tears, distal radioulnar joint reactive marrow edema, synovitis, scapholunate ligament sprain, full-thickness degenerative tear of the membranous portion, lunotriquetral ligament sprain, partial tear, distal radius, ulnar, carpal reactive marrow edema; dorsal synovitis, and triquetrum lunate chondromalacia.

Appellant was treated by Joseph Jones and Jamie Meyer, physician assistants, from May 6 through July 15, 2016, for two left wrist injuries that occurred in April and May 2016 while at work. Mr. Jones diagnosed pain in the left wrist, Vitamin D deficiency, and hypothyroidism.

On June 27, 2016 Dr. Puddy treated appellant for persistent left wrist pain. He described two left wrist injuries that occurred at work on April 11 and May 11, 2016. Findings on examination revealed tenderness overlying the ulnocarpal joint and radiocarpal joint, mild scapholunate widening, and positive ulnar variance. Dr. Puddy diagnosed left wrist pain.

Dr. Mary Finn, a Board-certified orthopedist, evaluated appellant on July 25, 2016 for a history of left wrist pain that began on April 11, 2016 when moving a water table at work. Appellant reported ulnar-sided left wrist pain that started to subside until a child at work struck her on the left wrist. Findings on examination revealed diffuse tenderness overlying the ulnocarpal joint. X-rays of the left wrist revealed distal radial ulnar joint widening, ulnar positive variance, and scapholunate interval. Dr. Finn diagnosed wrist pain, unspecified. She opined that although the ligamentous findings were likely related to trauma the bony findings were chronic in nature and therefore unrelated to the current symptoms.

Dr. Joshua Y. Young, a Board-certified orthopedic surgeon, treated appellant on August 18, 2016 for possible ulnar impaction syndrome of the left wrist. He noted a history of two left wrist injuries occurring at work on April 11, 2016 and another occurring at an unspecified date. Findings on examination revealed diffuse tenderness overlying the ulnocarpal join and ulnar head and tenderness over the ulnar TFCC. Dr. Young diagnosed left wrist pain and recommended a wrist arthroscopy. In reports dated September 19 and October 13 and 28, 2016, he saw appellant in surgical aftercare noting that she was status post left wrist arthroscopy and ulnar shortening osteotomy. In a work excuse dated September 19, 2016, Dr. Young noted that she was off work until September 28, 2016 and then released to administrative duties with no lifting. He treated appellant on November 15, 2016 for persistent left wrist pain. Dr. Young noted that she injured her left wrist on April 11, 2016 while moving a heavy object at work, which was resolving when she was struck on her left wrist by a child at work. Appellant was status post left wrist arthroscopy and ulnar shortening osteotomy on September 13, 2016. Dr. Young diagnosed progressive lesion of the ulnar nerve left upper limb and recommended hardware removal of her left forearm and ulnar nerve exploration. In a work excuse dated December 8, 2016, he noted that appellant could work light duty through February 8, 2017. In duty status reports (Form CA-17) dated April 24 and May 10, 2017, Dr. Young noted that the diagnosis due to injury was "TFCC tear" and ulnar nerve palsy and returned her to modified-duty work.

On November 14, 2016 appellant was evaluated by Dr. Karen Bellini, a Board-certified neurologist, for ulnar nerve palsy and possible conduction delay between the elbow and the wrist. She noted that appellant was status post-arthroscopic surgery in September 2016 and experienced clawing of the fourth and fifth fingers, wasting of the thenar and hypothenar eminences, paresis of ulnar innervated hand muscles, and decreased sensation in ulnar distribution over palmar and dorsal aspects of the left hand. An x-ray of the left wrist revealed ulnar postsurgical changes without complications. Dr. Bellini indicated that the injury was localized to the humeral-ulnar

aponeurosis, the cause and severity was unclear, with possible etiologies of neurapraxia and axonotmesis from surgery, cast compression, or a combination of both. She diagnosed lesion of the ulnar nerve, left upper limb and pain in the left hand. On November 22, 2016 Dr. Young performed a left forearm hardware removal, ulnar neurolysis and diagnosed left ulnar nerve palsy. He treated appellant postoperatively on January 23 and March 13, 2017 and noted a history of work injuries occurring on April 11 and May 11, 2016. An x-ray revealed interval healing with some callus formation. Dr. Young noted that appellant was limited by flexion contracture on her small finger and extension contracture of her thumb.

On February 8 and 10, 2017 appellant was treated by Nathan Hamilton, a physician assistant, for hypothyroidism, fatigue, and a general feeling of malaise, which began around the time of her April 11, 2016 wrist injury. Mr. Hamilton diagnosed adjustment disorder, unspecified, and Vitamin D deficiency.

Appellant was seen in consultation with James Hopkinson-Woolley, an orthopedic hand surgeon, on February 27, 2017 for loss of use of her left hand. She reported injuring her left wrist in April 2016 and then knocked her wrist at work when her symptoms deteriorated. Mr. Hopkinson-Woolley diagnosed loss of dexterity of the left hand following ulnar nerve injury in association with ulnar shortening osteotomy.

In a June 15, 2017 memorandum, Dr. Young reported treating appellant since August 18, 2016 for two left wrist injuries. On July 1, 2017 he asserted that the injuries she sustained on April 11 and May 11, 2016 were related and both occurred at work. Dr. Young diagnosed soft tissue TFCC tear. He opined that it was the cumulative effect of both injuries that sent appellant to his clinic. In a work excuse form dated June 12, 2017, Dr. Young released her to light duty on August 12, 2017.

On June 23, 2017 appellant was treated by Mr. Hamilton, a physician assistant, for a left wrist injury that occurred on April 11, 2016. Findings on examination revealed abnormal motion of the left hand and weakness of the fingers. Mr. Hamilton diagnosed lesion of the ulnar nerve, left upper limb and opined that it was reasonable to conclude that appellant's wrist injury and subsequent encounters are all related to her April 11, 2016 employment injury.

On July 18, 2017 appellant requested reconsideration of the decision dated August 3, 2016, under OWCP File No. xxxxxx798.

By decision dated October 16, 2017, OWCP denied modification of its August 3, 2016 decision.

On September 13, 2018 appellant requested reconsideration. She submitted a report dated August 14, 2018 from Dr. Young, who treated her for a symptomatic TFCC tear. Appellant reported injuring her left wrist on April 11, 2016 when she was moving a water table. She reported that her ulnar-sided left wrist pain was subsiding when she was struck on her left wrist by a child at work on May 11, 2016. Dr. Young opined that this episode resulted in increased pain radiating proximally that did not subside until she had left wrist surgery. He noted that appellant had nerve complications relating to the surgery, which left her with residual disability. Dr. Young opined that the two injuries were the direct cause of her wrist pain and surgery. He advised that, although ulnar positive variance may predispose appellant to a wrist injury, it was the two injuries themselves that caused pain and disability.

By decision dated October 24, 2018, OWCP denied modification of the October 16, 2017 decision.

An electromyogram (EMG) and nerve conduction velocity (NCV) study dated September 26, 2018 revealed moderate left, mildly axonometric motor and sensory ulnar mononeuropathy just proximal to the left wrist at the medial distal forearm, mild-to-moderate left neurapraxia, and ulnar neuropathy at the elbow.

On December 13, 2018 appellant appealed to the Board under OWCP File No. xxxxxx798.[6] By decision dated May 18, 2020, the Board set aside the October 24, 2018 decision and remanded the case with instructions to administratively combine OWCP File Nos. xxxxxx798 and xxxxxx799, to be followed by a *de novo* decision.

Upon return of the case record, OWCP administratively combined OWCP File Nos. xxxxxx799 and xxxxxx798, with xxxxxx798 designated as the master file.

While the appeal was pending before the Board, appellant submitted a report from Dr. Aaron M. McGuire, an osteopath and Board-certified physiatrist, who diagnosed left wrist sprain, ulnar impaction syndrome, TFCC tear at the ulnar attachment, and axonal ulnar mononeuropathy. Dr. McGuire noted that on April 11, 2016 appellant was emptying water out of a sensory table and twisted her left wrist resulting in a diagnosis of acute sprain. He further noted that on May 12, 2016 she was dealing with an unruly child who punched her in the right wrist. Dr. McGuire opined that appellant sustained 14.5 percent permanent impairment of the left upper extremity. He opined, to a reasonable degree of medical certainty, that her injuries arose out of and are a direct result of the work-related injury she sustained on April 11, 2016 with a secondary injury on May 12, 2016.

By decision dated July 17, 2020, OWCP denied modification.

LEGAL PRECEDENT

An employee seeking benefits under FECA[7] 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,[8] 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

[6] *Supra* note 4.

[7] *Supra* note 2.

[8] *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).

employment injury.[9] 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.[10]

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. First, the employee must submit sufficient evidence to establish that he or she actually experienced the employment incident at the time and place, and in the manner alleged. Second, the employee must submit sufficient evidence to establish that the employment incident caused a personal injury.[11]

The medical evidence required to establish a causal relationship between a claimed specific condition and an employment incident is rationalized medical opinion evidence.[12] 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 factors identified by the employee.[13]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish a left wrist condition causally related to the accepted May 11, 2016 employment incident.

In reports dated June 15 and July 1, 2017, Dr. Young opined that appellant's injuries sustained on April 11 and May 11, 2016 were related and occurred at work. He diagnosed soft tissue TFCC tear and opined that the cumulative effect of both wrist injuries sent her to his clinic. Similarly, on August 14, 2018 Dr. Young reported that appellant sustained a previous twisting injury to her left wrist while moving a water table on April 11, 2016. Appellant subsequently reported being struck on her left wrist by a child at work on May 11, 2016. Dr. Young opined that these two injuries were the direct cause of her wrist pain that surgery. The Board finds that, although he supported causal relationship, he did not provide medical rationale explaining the basis of his conclusory opinion regarding the causal relationship between appellant's left wrist condition and the May 11, 2016 employment incident.[14] Dr. Young did not explain the process by which being struck on her left wrist by a child on May 11, 2016 would have caused the diagnosed

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[9] *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).

[10] *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).

[11] *T.J.*, Docket No. 19-0461 (issued August 11, 2020); *K.L.*, Docket No. 18-1029 (issued January 9, 2019); *John J. Carlone*, 41 ECAB 354 (1989).

[12] *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).

[13] *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).

[14] *See T.M.*, Docket No. 08-975 (issued February 6, 2009) (a medical report is of limited probative value on the issue of causal relationship if it contains a conclusion regarding causal relationship which is unsupported by medical rationale).

conditions. As the opinion of appellant's physician regarding causal relationship was conclusory and unexplained, it was insufficient to meet appellant's burden of proof. These reports are thus insufficient to establish appellant's claim.[15]

Dr. Young treated appellant on August 18, 2016 for possible ulnar impaction syndrome of the left wrist. He noted a history of two left wrist injuries occurring at work on April 11 and May 11, 2016. Dr. Young diagnosed left wrist pain. In reports dated September 19, and October 13 and 28, 2016, he saw appellant in surgical aftercare for a left wrist arthroscopy. Similarly, in reports dated November 15 and 22, 2016 and January 23 and March 13, 2017, Dr. Young noted that she injured her left wrist on April 11, 2016 while moving a heavy object at work, which was healing when she was struck by a child at work. He diagnosed progressive lesion of the ulnar nerve left upper limb. The Board has held, however, that medical evidence that does not offer an opinion regarding the cause of an employee's condition or disability is of no probative value on the issue of causal relationship.[16] These reports are, therefore, insufficient to establish appellant's claim.

In a work excuse note dated September 19, 2016, Dr. Young noted that appellant was off work until September 28, 2016 and then released to administrative duties. In other work excuse notes dated December 8, 2016 and June 12, 2017, he released her to light duty through February 8, 2017 and then extended it through August 12, 2017. Similarly, in CA-17 forms dated April 24 and May 10, 2017, Dr. Young noted the diagnosis due to injury was "TFCC tear" and ulnar nerve palsy and returned appellant to light-duty work. In these notes that he did not offer an opinion as to whether a diagnosed condition was causally related to the accepted May 11, 2016 employment incident. 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.[17] These notes from Dr. Young are, therefore, insufficient to establish appellant's claim.

In a work/school excuse form dated June 27, 2016, Dr. Puddy recommended light duty. In a July 21, 2016 memorandum, he treated appellant for a left wrist injury sustained at work. Similarly, on July 21, 2016 Dr. Puddy treated her for left wrist pain that began on April 11, 2016 when she was moving a water table. Appellant reported being subsequently struck by a child on her left wrist while at work. Dr. Puddy noted that an MRI scan arthrogram of the left wrist demonstrated a TFCC tear and he opined that the tears were consistent with wrist trauma. However, Dr. Puddy did not address whether appellant's employment activities on May 11, 2016 had caused or aggravated a diagnosed medical condition.[18] Therefore, these reports are insufficient to meet appellant's burden of proof.

Dr. Finn evaluated appellant on July 25, 2016 for left wrist pain that began on April 11, 2016 when moving a water table at work. Appellant reported a subsequent injury occurred when she was struck by a child at work on the left wrist. Dr. Finn, however, did not address whether

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[15] *J.M.*, 58 ECAB 478 (2007).

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

[17] *Id.*

[18] *Id.*

appellant's employment activities on May 11, 2016 caused or aggravated a diagnosed medical condition. As such, the medical note by Dr. Finn is of no probative value and is insufficient to establish appellant's claim.[19]

On November 14, 2016 Dr. Bellini treated appellant for ulnar nerve palsy. She indicated that the injury was localized to the humeral-ulnar aponeurosis, the cause and severity was unclear, with several possible etiologies. Dr. Bellini diagnosed lesion of the ulnar nerve, left upper limb, and pain in the left hand. As this report does not provide an opinion on causal relationship between appellant's diagnosed conditions and the accepted May 11, 2016 employment incident, this report is also of no probative value and is insufficient to meet appellant's burden of proof.[20]

Appellant submitted a September 23, 2019 report from Dr. McGuire who diagnosed left wrist sprain and ulnar impaction syndrome, TFCC tear at the ulnar attachment, and axonal ulnar mononeuropathy. Dr. McGuire noted a history of the April 11, 2016 work injury. He further noted that on May 12, 2016 appellant was dealing with an unruly child who punched her in the right wrist. Dr. McGuire opined to a reasonable degree of medical certainty that appellant's injuries arose out of and are a direct result of the work-related injury she sustained on April 11, 2016 with a secondary injury on May 12, 2016. However, the record reveals that the injury was to the left wrist and occurred on May 11, 2016. The Board has held that medical opinions based on an incomplete or inaccurate history are of limited probative value.[21] This report is, therefore, insufficient to establish appellant's claim.

Appellant was evaluated by several physician assistants. The Board has held that medical reports signed solely by a physician assistant[22] are of no probative value as such health care providers are not considered "physician[s]" as defined under FECA.[23] Consequently, this evidence is insufficient to establish appellant's claim.[24]

Appellant also submitted diagnostic studies including x-rays, a left wrist MRI scan arthrogram, an EMG/NCV study. The Board has held that diagnostic test reports, standing alone, lack probative value on the issue of causal relationship as they do not provide an opinion as to

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[19] *Id.*

[20] *Id.*

[21] *G.E.*, Docket No. 19-1190 (issued November 26, 2019); *T.O.*, Docket No. 17-0093 (issued March 22, 2018).

[22] *See S.E.*, Docket No. 08-2214 (issued May 6, 2009) (reports of a physician assistant have no probative value as medical evidence).

[23] 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).

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

whether the accepted employment incident caused a diagnosed condition.[25] These diagnostic reports are therefore also insufficient to establish appellant's claim.

As the medical evidence of record is insufficient to establish causal relationship between a left wrist condition and the accepted May 11, 2016 employment incident, 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 a left wrist condition causally related to the accepted May 11, 2016 employment incident.

[25] *A.P.*, Docket No 18-1690 (issued December 12, 2019).

ORDER

IT IS HEREBY ORDERED THAT the July 17, 2020 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: August 26, 2021
Washington, DC

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

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

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