United States Department of Labor
Employees' Compensation Appeals Board

V.L., Appellant	)	
and	)	**Docket No. 20-0884**
	)	**Issued: February 12, 2021**
DEPARTMENT OF VETERANS AFFAIRS, ST. ALBANS HARBOR HEALTHCARE SYSTEM, Jamaica, NY, 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 March 16, 2020 appellant, through counsel, filed a timely appeal from a February 27, 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.

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[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.*

ISSUE

The issue is whether appellant has met her burden of proof to establish a medical condition causally related to the accepted September 20, 2017 employment incident.

FACTUAL HISTORY

On September 25, 2017 appellant, then a 54-year-old nurse, filed a traumatic injury claim (Form CA-1) alleging that at 8:45 a.m. on September 20, 2017 she walked into the lounge to treat a patient and slipped and fell on a wet floor injuring her left shoulder, lower back, right hip, and right buttock while in the performance of duty. On the reverse side of the claim form, appellant's nurse manager, K.P. indicated that appellant was not on duty at the time of the fall. K.P. noted that appellant's shift was from 12:00 a.m. to 8:00 a.m. and the fall occurred at 8:45 a.m. after she gave her report to the oncoming shift. Appellant did not immediately stop work.

In a duty status report (Form CA-17) dated September 20, 2017, Dr. Todd A. Halper, a Board-certified family practitioner, noted clinical findings of low back, hip, and bilateral shoulder pain and diagnosed muscle spasm. He returned appellant to work full time with restrictions. In a return to work note dated September 25, 2017, Dr. Halper held appellant off work for one week.

In a September 25, 2017 authorization for examination and/or treatment (Form CA-16), the employing establishing authorized appellant to seek medical care. In Part B of the Form CA-16, attending physician's report, of even date, Dr. Halper reported that appellant slipped and fell on a puddle and injured her low back, left shoulder, and right hip/leg. He diagnosed left shoulder, lumbar, and right hip sprain and right leg pain. Dr. Halper checked a box marked "Yes" indicating that the diagnosed conditions were caused or aggravated by the described employment activity. He further indicated that appellant was totally disabled from work beginning September 22, 2017.

In an October 4, 2017 development letter, OWCP informed appellant that the evidence submitted was insufficient to establish her claim. It advised her of the type of factual and medical evidence needed and provided a questionnaire for her completion. OWCP afforded appellant 30 days to submit the requested information.

An x-ray of the lumbar spine dated October 3, 2017, revealed mild scoliosis and mild degenerative findings at L4-5.

Dr. Halper treated appellant in follow up on October 9, 2017 for an injury sustained at work on September 20, 2017. Appellant complained of left shoulder, low back, and right hip pain with numbness/tingling down the right leg. Dr. Halper diagnosed sprain of the left shoulder, lumbar spine and right hip, subsequent encounter, lumbar radiculopathy, right leg pain, and disturbances of skin sensation and found appellant totally disabled.

Appellant was treated by Dr. Crispin Ong, a Board-certified orthopedist, on October 10, 2017 for low back and buttock pain. She reported slipping and falling on a wet floor at work and injuring her back and left shoulder. Examination of the low back revealed tenderness to palpation over the paraspinal muscles on the right, positive straight leg raises, and positive impingement

sign, Neer, and Hawkins testing of the left shoulder. Dr. Ong noted that x-rays of the pelvis and shoulder revealed no evidence of fracture or dislocation. X-rays of the lumbar spine revealed decreased disc space at L5-S1. Dr. Ong diagnosed low back pain, lumbar radiculopathy, and left shoulder pain.

In an October 14, 2017 response to the development letter, appellant indicated that on September 20, 2017 she worked the night shift and after making rounds she gave a report to the incoming shift. After the report she went to the lounge where the residents had breakfast to take the pulse of a resident that was elevated prior to being medicated. Appellant noted that as she walked into the lounge she started to slide and realized she stepped into water and fell on her back. She asserted that she was in the performance of duty when the incident occurred as she had just finished giving the shift report and went to take a resident's pulse to complete the report.

A medical report from Dr. Harold Augenstein, a Board-certified radiologist, dated November 6, 2017, diagnosed low back pain and degenerative disc disease of the lumbar region.

By decision dated November 16, 2017, OWCP denied appellant's traumatic injury claim, finding that the evidence submitted was insufficient to establish that an injury and/or medical condition "arose during the course of employment and within the scope of compensable work factors. "It explained that the injury occurred 45 minutes after her shift ended.

Dr. Halper treated appellant from September 25 through November 6, 2017, for left shoulder, low back, and right hip/leg pain with numbness down the right leg, which developed on September 20, 2017, when she slipped and fell on a puddle of water at work. He diagnosed sprain of the left shoulder, lumbar spine, and right hip, lumbar radiculopathy and disturbances of the skin sensation, Dr. Halper opined that appellant was totally disabled.

Appellant attended physical therapy treatment from October 5 through November 18, 2017.

On October 24, 2017 Dr. Ong reevaluated appellant and diagnosed low back pain, lumbar radiculopathy, and bilateral shoulder pain. In reports dated November 20 and December 18, 2017, and January 15, 2018, he treated her for persistent lower back, bilateral shoulder, and neck pain. Findings on examination revealed tenderness to palpation over the paraspinal muscles of the cervical spine and tenderness of the low back. Dr. Ong diagnosed cervicalgia, cervical radiculopathy, bilateral shoulder pain and lumbar radiculopathy.

A November 15, 2017 magnetic resonance imaging (MRI) scan of the right shoulder revealed supraspinatus/infraspinatus tendinopathy, no tear, acromioclavicular arthritis, low lying acromion, and bursitis.

On November 28, 2017 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review.

In a statement dated January 2, 2018, appellant indicated that it was not unusual for a nurse to stay after the shift time frame to finish documentation. She relayed that she had just finished giving a report to the incoming nurse and part of the report involved taking the pulse of a resident that was elevated prior to taking medication.

Following a preliminary review, by decision dated April 20, 2018, an OWCP hearing representative set aside the decision dated November 16, 2017 and remanded the case for further development.

An MRI scan of the cervical spine dated February 27, 2018, revealed disc desiccation with posterior disc margin preservation at C2-3, C3-4, and C4-5, posterior disc osteophyte complex with small midline extrusion with left and right neural foraminal narrowing, and minimal posterior broad-based disc herniation.

An MRI scan of the lumbar spine dated February 28, 2018 revealed disc desiccation, left paracentral herniation of the disc producing mild foraminal narrowing at L3-4, left foraminal herniation of the disc producing moderate-to-severe left foraminal narrowing at L4-5, and right paracentral herniation of the disc producing mild right foraminal narrowing at L5-S1.

Appellant came under the treatment of Dr. Stelios Koutsoumbelis, a Board-certified orthopedist, on April 9, 2018 for back and neck pain following a work-related injury. He diagnosed back pain with foraminal stenosis at L4-5 and recommended an epidural steroid injection at L4-5. On May 7 and July 16, 2018 Dr. Koutsoumbelis treated appellant in follow up and she reported undergoing two epidural steroid injections with partial relief in symptoms.

In a development letter dated April 23, 2018, OWCP requested the employing establishment respond to a questionnaire addressing the accuracy of appellant's statements. It afforded the employing establishment 30 days to submit the requested information.

In response to OWCP's development letter the employing establishment submitted an unsigned statement from a supervisor who noted that appellant's shift was from 12:00 a.m. to 8:00 a.m. The supervisor noted that protocol required that the employee obtain approval from her supervisor if she stays after her shift. The supervisor was informed by two registered nurses from the day tour that appellant was found sitting in the day room at about 9:00 a.m. on September 20, 2017. It was noted as common practice that as soon as you gave "hands on communication" to the incoming shift you leave all issues discussed with the oncoming tour to follow-up. The supervisor reported having no knowledge that appellant stayed at work after her shift ended at 8:00 a.m.

On June 21, 2018 appellant was seen in neurologic consultation by Dr. Mohammad Husain, a Board-certified neurologist, for chronic neck and back pain with numbness in the legs, which developed after a fall at work in September 2017. Dr. Husain diagnosed status post fall at work in 2017 with chronic neck and back pain, disc herniations of the cervical and lumbar spine, status post epidural injection, numbness in both lower extremities, and history of diabetes rule out neuropathy. He recommended an electromyogram/nerve conduction velocity study (EMG/NCV).

By decision dated September 7, 2018, OWCP denied appellant's claim for compensation because the evidence was insufficient to establish that she was injured in the performance of duty.

OWCP received additional evidence. In reports dated February 13 through April 2, 2018, Dr. Ong noted findings on examination of tenderness to palpation over the paraspinal muscles of the lumbar and cervical spine. He diagnosed cervicalgia, cervical radiculopathy, bilateral shoulder pain, lumbar and cervical disc disease, and lumbar radiculopathy and took appellant off work.

On June 18, 2018 Dr. Koutsoumbelis diagnosed foraminal stenosis and back pain consistent with neurogenic claudication. He noted that appellant was temporarily totally disabled. Appellant presented on September 6, 2018, with improvement in her pain level after the second steroid injection. Dr. Koutsoumbelis diagnosed foraminal stenosis, back pain, and lumbar radiculopathy and advised that she was totally disabled for one month. On October 4, 2018 he diagnosed foraminal stenosis and indicated that appellant would be off work for one additional month.

On September 14, 2018 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. The hearing was held on February 13, 2019.

In a March 6, 2019 statement, the employing establishment manager, K.P., asserted that appellant was not in the performance of duty at the time of the incident as her tour of duty was from 12:00 a.m. to 8:00 a.m. and she did not have the approval of a supervisor to stay later.

An MRI scan of the lumbar spine dated March 22, 2019 revealed mild-to-moderate disc bulging at the L3-4 and L4-5, moderate to large right paracentral disc extrusion at L5-S1 impinging on the descending right S1 nerve root.

By decision dated April 30, 2019, the hearing representative vacated the September 7, 2018 decision and remanded the case for further development.

On April 11, 2019 appellant was admitted to the hospital for low back pain status post right L5-S1 discectomy on April 4, 2019. Dr. Elizabeth Efthimiou, a Board-certified physiatrist, diagnosed lumbar disc disease with radiculopathy, hyperparathyroidism, hyperlipidemia, elevated liver functions, and diabetes mellitus.

In a May 2, 2019 development letter, OWCP requested that the employing establishment identify agency regulations violated by appellant by staying past her shift, policies that address the duties of an incoming shift, and agency enforcement of rules and policies.

In response to OWCP's development letter, the employing establishment submitted an unsigned May 21, 2019 statement from the nurse manager K.P. who indicated that appellant was aware of her shift routine through education and nursing. K.P. noted that nursing responsibilities included distribution of workload to maximize time, supplies, and staff in a safe and efficient manner. She explained that nursing was about team work and tasks not performed by one shift were left for completion by the oncoming shift. In this instance the resident's pulse could have been taken by the day shift. K.P. further noted that because nursing was a complex job the staff did not hang around and socialize. She indicated that appellant was scheduled to leave her unit at 8:00 a.m. and on this particular day she failed to inform the nurse manager that she stayed beyond her tour. K.P. noted that it was best practice that required a staff member who stayed after her scheduled tour to contact the nurse manager.

By decision dated August 28, 2019, OWCP denied appellant's traumatic injury claim, finding that the medical evidence submitted was insufficient to establish causal relationship between her diagnosed conditions and the accepted September 20, 2017 employment incident.

An MRI scan of the lumbar spine dated May 20, 2017 revealed multiple disc herniations in exiting the L3 nerve root impingement at L3-4, impingement upon existing L4 nerve root at L4-5, and impingement upon the right S1 nerve root with encroachment upon the exiting L5 nerve root at L5-S1.

Appellant came under the treatment of Dr. Michael A. Lefkowitz, a Board-certified neurologist, on March 1 and 26, 2019, who diagnosed lumbar disc herniation, right lumbar radiculopathy, diabetes, thyroid nodule, and hyperlipidemia. Dr. Lefkowitz noted that she failed nonsurgical treatment and he recommended a right L5-S1 discectomy. On April 4, 2019 he performed a right L5-S1 discectomy and diagnosed right L5-S1 disc herniation and right leg radiculopathy. On April 30, 2019 Dr. Lefkowitz noted that appellant was status post right L5-S1 discectomy and her low back and right leg pain largely resolved. He diagnosed postoperative state, right lumbar radiculopathy, and lumbar disc herniation. Dr. Lefkowitz treated appellant in follow up on June 28 and July 12, 2019, for right buttock pain radiating down the back of her right thigh and calf. He recommended physical therapy and an updated MRI scan of the lumbar spine.

On September 11, 2019 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. The hearing was held on January 14, 2020.

Subsequent to the oral hearing, appellant submitted additional medical evidence. On December 27, 2019 and January 28, 2020 she was treated by Dr. Jean-Robert Desrouleaux, a Board-certified neurologist, for excruciating back pain radiating to the right buttock and thigh. Appellant reported that on September 20, 2017 while at work she slipped on a wet floor and fell. Conservative treatment failed and on April 4, 2019 she underwent an L5-S1 discectomy, which provided partial relief of pain. Dr. Desrouleaux diagnosed right L5 radiculopathy, status post right lumbar discectomy. He opined that "if" the history taken was true the symptoms appellant experienced were the direct result of the accident sustained on September 20, 2017. Dr. Desrouleaux noted that she had a brief episode of pain in 2017 that lasted about three weeks and resolved and she remained asymptomatic until September 20, 2017.

By decision dated February 27, 2020, an OWCP hearing representative affirmed the August 28, 2019 decision.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] has the burden of proof to establish the essential elements of his or her claim, including that the individual is an employee of the United States within the meaning of FECA, that the claim was timely filed within the applicable time limitation of FECA,[4] that an injury was sustained in the performance of duty as alleged, and that any disability or medical condition for which compensation is claimed is causally related to the

[3] *Id.*

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

employment injury.[5] These are the essential elements of each and every compensation claim, regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[6]

To determine whether a federal employee has sustained a traumatic injury in the performance of duty, it first must be determined whether fact of injury has been established. First, the employee must submit sufficient evidence to establish that he or she actually experienced the employment incident at the time, place, and in the manner alleged. Second, the employee must submit sufficient evidence to establish that the employment incident caused a personal injury.[7]

The medical evidence required to establish causal relationship is rationalized medical opinion evidence.[8] The opinion of the physician must be based on a complete factual and medical background of the employee, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and specific employment incidents identified by the employee.[9]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish a medical condition causally related to the accepted September 20, 2017 employment incident.

Dr. Halper treated appellant from September 25 through November 6, 2017 for left shoulder, low back, and radiating right hip/leg pain, which developed at work when she slipped and fell on a puddle of water on September 20, 2017. He diagnosed sprain of the left shoulder, lumbar spine and right hip, lumbar radiculopathy, right leg pain, and disturbances of skin sensation and found appellant totally disabled. Reports from Dr. Ong dated October 10, 2017 through April 2, 2018 described appellant's treatment for lower back, bilateral shoulder, and radiating neck pain. He diagnosed low back pain, lumbar radiculopathy, cervicalgia, cervical radiculopathy, bilateral shoulder pain, lumbar and cervical disc disease, and lumbar radiculopathy and noted appellant was totally disabled. In a Form CA-17 dated September 20, 2017, Dr. Halper diagnosed muscle spasm and returned appellant to work full time with restrictions. In a return to work note dated September 25, 2017, he opined that she was disabled for one week. Similarly, a November 6, 2017 report from Dr. Augenstein diagnosed low back pain and degenerative disc disease of the lumbar region. Reports from Dr. Lefkowitz dated March 1 through July 12, 2019 diagnosed lumbar disc herniation, right lumbar radiculopathy, diabetes, thyroid nodule, and hyperlipidemia.

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

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

[7] *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).

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

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

Likewise, an April 11, 2019 report from Dr. Efthimiou diagnosed lumbar disc disease with radiculopathy, hyperparathyroidism, hyperlipidemia, elevated liver functions, and diabetes mellitus. However, none of these physicians offered an opinion on causal relationship. The Board has held that medical evidence that does not offer an opinion regarding the cause of an employee's condition or disability is of no probative value on the issue of causal relationship.[10] Therefore, these reports are insufficient to establish appellant's claim.

In reports dated April 9 through October 4, 2018, Dr. Koutsoumbelis diagnosed back pain consistent with neurogenic claudication, foraminal stenosis at L4-5, and lumbar radiculopathy. Similarly, on June 21, 2018, Dr. Husain treated appellant for chronic neck and back pain with numbness in the legs and diagnosed status post fall at work in 2017 with chronic neck and back pain, disc herniations of the cervical and lumbar spine, numbness in both the lower extremities, and history of diabetes rule out neuropathy. However, such generalized statements do not establish causal relationship because they merely repeat appellant's allegations and are unsupported by adequate medical rationale explaining how the accepted September 20, 2017 employment incident actually caused a diagnosed medical condition.[11] The Board has held that a report is of limited probative value regarding causal relationship if it does not contain medical rationale explaining how an employment activity could have caused or aggravated a medical condition.[12] Thus, these reports are of limited probative value and insufficient to establish that appellant sustained an employment-related injury.

Appellant was treated by Dr. Desrouleaux on December 27, 2019 and January 28, 2020, who diagnosed right L5 radiculopathy, status post right lumbar discectomy and opined that "if" the history taken was true the symptoms appellant experienced were the direct result of the accident sustained on September 20, 2017. Dr. Desrouleaux's opinion is speculative in nature. The Board has held that medical opinions that are speculative or equivocal are of diminished probative value.[13] An award of compensation may not be based on surmise, conjecture, speculation or upon appellant's own belief that there is causal relationship between her claimed condition and her employment.[14]

Appellant submitted physical therapy reports dated October 5 through November 18, 2017. However, certain healthcare providers such as physician assistants, nurses, nurse practitioners, physical therapists, and social workers are not considered "physician[s]" as defined under FECA.

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

[11] *See J.B.*, Docket No. 18-1006 (issued May 3, 2019).

[12] *See Y.D.*, Docket No. 16-1896 (issued February 10, 2017).

[13] *H.A.,* Docket No. 18-1455 (issued August 23, 2019).

[14] *See id.*

Consequently, their medical findings and/or opinions will not suffice for purposes of establishing entitlement to FECA benefits.[15]

Appellant also submitted MRI scans of the lumbar and cervical spine and right shoulder and an x-ray of the lumbar spine. The Board has explained that diagnostic studies, standing alone, lack probative value as they do not address whether the employment incident caused any of the diagnosed conditions.[16]

As the case record does not contain rationalized medical evidence sufficient to establish causal relationship between the accepted September 20, 2017 employment incident and her diagnosed conditions, the Board finds that appellant has not met her burden of proof.

On appeal appellant asserts that she submitted sufficient evidence to establish her fall at work caused her diagnosed lumbar conditions. However, as explained above, she has not submitted rationalized medical evidence sufficient to establish her claim.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish a medical condition causally related to the accepted September 20, 2017 employment incident.[17]

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[15] Section 8102(2) of FECA provides as follows: (2) 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); *see also J.R.*, Docket No. 20-0496 (issued August 13, 2020) (physical therapists are not considered physicians under FECA); *see also S.L.*, Docket No. 19-0603 (issued January 28, 2020) (a nurse is not considered a physician as defined under FECA).

[16] *R.C.*, Docket No. 19-0376 (issued July 15, 2019).

[17] The Board notes that the employing establishment issued a Form CA-16. A properly executed Form CA-16 authorization may constitute a contract for payment of medical expenses to a medical facility or physician, when properly executed. The form creates a contractual obligation, which does not involve the employee directly, to pay for the cost of the examination or treatment regardless of the action taken on the claim. The period for which treatment is authorized by a Form CA-16 is limited to 60 days from the date of issuance, unless terminated earlier by OWCP. 20 C.F.R. § 10.300(c); *P.R.,* Docket No. 18-0737 (issued November 2, 2018); *N.M.,* Docket No. 17-1655 (issued January 24, 2018); *Tracy P. Spillane,* 54 ECAB 608 (2003).

ORDER

IT IS HEREBY ORDERED THAT the February 27, 2020 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: February 12, 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