File Number:
HR10-D-H

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Date of Injury:
Employee:

Dea

This is in reference to your workers' compensation claim. Pursuant to your request for a hearing, the case file was transferred to the Branch of Hearings and Review.

A hearing was held or As a result of such hearing, it has been determined that the decision issued by the District Office should be vacated and the case remanded to the district office for further action as explained in the enclosed copy of the Hearing Representative's Decision.

Your case file has been returned to the Jacksonville District Office. You may contact that office by writing to our Central Mail Room at the following address:

US DEPARTMENT OF LABOR
OWCP/DFEC, PO Box 8311
LONDON, KY 40742-8311

Sincerely,

Division of Federal Employees' Compensation

PAUL FELSER
7393 HODGSON MEMORIAL DRIVE
SUITE 102
SAVANNAH, GA 31406

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodation(s) and/or modification(s), please contact OWCP.

Washington DC, September 01, 2020

U.S. DEPARTMENT OF LABOR
Office of Workers' Compensation Programs

DECISION OF THE HEARING REPRESENTATIVE

In the matter of the claim for compensation under Title 5. U.S. Code 8101 et. seq. of
Claimant; Employed by , Case No.

An Oral Hearing was held on . As a result, the decision of the District Office dated has been set aside, and the case has been remanded for additional actions, for the reasons set forth below:

The issue for determination is whether the evidence of record is sufficient to establish that the claimant sustained a work-related injury in the performance of duty, in the manner alleged.

The claimant is an employee of the where she works as a . She filed form CA-1 "Notice of Traumatic Injury" on alleging she was injured at work on due to a motor vehicle accident when she was stopped on Drive in front of , turned on her left turn signal and was rear-ended. The claimant indicated she sustained a severe concussion, pain in the left side of her neck, shoulder pain, severe pain in the lower back and left knee. On the back of form CA-1, advised that his knowledge of the facts was consistent with the claimant's statements and the claimant was in the performance of duty at the time of the incident. Also, medical care was received on the date of the incident.

In a written statement dated the claimant provided additional discussion of the injury and surrounding circumstances. On , she was at work driving on Drive finishing her route for the day. Around 4:15 pm, she arrived at the front of the post office. She put her left turn signal on and came to a stop. While stopped, she looked for oncoming traffic. Before she had a chance to turn in to the post office driveway, she was hit very hard by another car in the rear end. She was pushed into the post office parking lot and ended up on the edge of the woods. She did not feel like she could get out of her car. Someone said they thought her car was on fire and she needed to get out. Someone else helped her out and sate her down. the Clerk in the came out to comfort her until the ambulance arrived. The woman that hit her asked if she was alright and the claimant told her no. Someone else asked if she was alright and she said yes. She stated she only looked down for a second and when she looked up, she saw the claimant's brake lights. The ambulance arrived. She was checked out and taken to the

Medical records received with the initial claim included discharge instructions from for cervical sprain and concussion, noting the claimant underwent CT of the brain, CT of the cervical spine and received medications. A prescription from Dr. of Family Practice dated referred the claimant for x-rays of the lumbosacral spine. A disability note from Dr. dated indicated the claimant was unable to work through

On the District Office issued a letter to the claimant advising that additional information was needed to support the claim. The claimant was asked to provide a copy of the accident report and a narrative report from her physician discussing the claimed injury, including

Washington DC, September 01, 2020

dates of examination and treatment, history and date of injury, detailed description of findings, results of all x-ray and laboratory tests, diagnosis, clinical course of treatment and physician's opinion supported by a medical explanation as to how the reported work incident caused or aggravated a medical condition. The claimant was advised she would be allowed an additional 30 days to provide evidence in support of the claim.

A copy of the accident report dated was received to the record, as requested. A letter from dated confirmed that the claimant was involved in a motor vehicle accident on the job on He advised that police cited the other driver and the claimant was taken to the hospital by ambulance. He gave the claimant additional information about authorization for medical treatment and filing a claim. He was advise the claimant would be off work through He had difficulty reaching her by phone despite several attempts and had not received any paperwork from her doctor visits.

The following additional medical documents were received to the record within the allowed period:

- Undated OWCP-5 "Work Capacity Evaluation" form by Dr. indicating the claimant was disabled from work for at least one month due to back pain, neck pain and radiculopathy.

- work excuse through from Healthcare signed by PA-C.

- CA-16 form completed by the employing agency on (front side only) authorizing emergency medical treatment.

- work excuse through by , PA-C of Family Practice.

- OWCP-5 "Work Capacity Evaluation" form by Dr. advising the claimant would be unable to work for 6 to 8 weeks due to severe muscle, arm and lower back pain.

- physical therapy referral by Dr.

On the District Office released a formal decision denying the claim with a finding that the medical evidence of record was insufficient to establish Fact of Injury. Although the work incident of was found factual, no medical evidence had been received from a physician providing a firm diagnosis in connection with the accident. Lacking a diagnosis, the medical evidence was insufficient to establish the claimant sustained an injury, as defined by the Act. Additionally, to meet the burden of proof, medical evidence was required to establish that a diagnosed medical condition was causally related to the established work incident. No medical evidence of that nature had been received.

The claimant disagreed with this decision and requested an appeal in the form of an Oral Hearing before the Branch of Hearings and Review. A Hearing was held by telephone on The claimant did not attend the Hearing. The claimant's authorized representative,

Attorney Paul Felser, attended the Hearing and offered argument on the record on behalf of the claimant. There was no representative from the employing agency present to observe the proceedings.

At the Hearing, Attorney Felser argued that the facts of the claim were clearly established. The claim was denied based on the medical evidence, which had not yet caught up with what certainly appeared to be a very clear-cut and straightforward on-the-job injury in the course of employment due to a motor vehicle accident. The standard for the claim was to establish a firm diagnosis and a causal connection to the work incident. The claimant was taken to the Emergency Room. According to the ER report by Dr. , the chief complaint was motor vehicle accident. The claimant was at the end of her route pulling into the post office when she was hit from behind. She was unrestrained as she does not wear a seatbelt for her job. The airbags deployed and she hit trees on the side of the road. She was mostly complaining of head and cervical neck pain. She was in a C-collar denying any alcohol or drug use that day. She was not complaining of other back pain, chest pain, shortness of breath or abdominal pain. She was ambulating on the scene afterward. She was hysterically crying in the room with severe pain in the back of her head and cervical spine.

Attorney Felser argued the jarring whiplash motion of such an event with force sufficient to deploy airbags, and the airbags themselves, would have been enough to cause injuries. The associated diagnosis in the ER report with respect to the accident was concussion and sprain of the trapezium. She was given literature regarding concussion and cervical sprain. Additional medical documents were also provided by Dr. noting she was suffering from radiculopathy and placing her in a no-work status. Attorney Felser argued this was ample evidence to accept the claim for the conditions identified by the ER physician following the injury directly attributed to the work event, without any dispute over the accident or evidence of a pre-existing injury. The claim could have been accepted easily for a bump, bruise, sprain, strain or contusion rather than denied outright. Additional conditions may be accepted in the future based on new medical evidence.

Attorney Felser indicated that he had encountered difficulty obtaining medical evidence in support of the claim due to the COVID19 pandemic, but he was attempting to do so. He asked that the record remain open for 30 days after the conclusion of the Hearing to allow for the submission of additional medical evidence for the appeal. The request was granted and the record held open. Copies of the transcript were released to the claimant, her representative and the employing agency. Their comments were invited. As of this date, no comments on the transcript have been received.

The following additional medical documents were received to the record in connection with the appeal:

- progress notes from the Emergency Room signed by PA-C and DO.
- CT cervical spine, no evidence of fracture or malalignment of cervical vertebrae.
- CT of the head and brain, no evidence of acute intracranial pathology or injury.

- progress notes from , PA-C, noting the claimant was seen in follow up after the ER and work-related motor vehicle accident on The claimant was reporting overall muscle aches/body aches and headache. X-rays would be obtained due to new onset of left knee pain.

- progress notes by Dr.

- progress notes by Dr.

- encounter notes by , MD, of the Spine Institute.

- encounter notes by

- MRI of the lumbar spine showing mild to moderate facet arthropatny and mild disc signal loss but no sign of root compression from L1 – L4; moderate facet arthropathy at L4-5 and mild signal loss but no sign of root compression; and L5-S1 moderate facet arthropathy, signal loss, disc dictation and mild listhesis with shallow protrusion, moderate probability of compression of the S1 root in the lateral recess. Opinion was multilevel mild-to-mild spondylosis with potential left-sided root compression L5-S1, noting an injury to the back on with aching and burning, low back and left leg pain.

- MRI of the cervical spine showing C2-3 disc/osteophyte complex with mild right and mild-to-moderate left foraminal stenosis; C3-4. disc/osteophyte complex with mild to moderate right and moderate left foraminal stenosis; C4-5. Disc/osteophyte complex with mild-to-moderate foraminal stenosis more pronounced on the left. Mild indentation or compression of the spinal cord with mild distortion but no myelopathic signal; C5-6 disc/osteophyte complex with mild-to-moderate foraminal stenosis; C6-7 disc/osteophyte complex with mild-to-moderate foraminal stenosis; C7-T1 mild spondylosis with no sign of root compression. Opinion was mild spinal cord compression without myelopathic signal and multilevel spondylosis, but no root compression had been documented, noting an injury to the neck on November 18, 2019 with aching right arm pain.

- procedure notes by Dr. for L5-S1 lumbar interlaminal epidural injection for lumbar degenerative disc disease with radiculopathy and lumbar radiculopathy.

- encounter note by , MD, of the Spine Institute.

- encounter notes by Dr.

- diagnostic report, EMG and Nerve Conduction Study, no electrodiagnostic evidence of cervical or lumbar radiculopathy or neuropathy.
- telemedicine encounter note by Dr.
- telemedicine encounter note by Dr.
- procedure notes by Dr. for bilateral L4-5, L5-S1 lumbar medial branch blocks for lumbar spondylosis and lumbar facet joint mediated pain.
- telemedicine encounter note by Dr.
- "Medication Summary Report" from through

The progress notes from the Emergency Room signed by PA-C and DO, noted that the claimant was seen for concussion and sprain of trapezium following a motor vehicle accident when she was pulling into the post office and was hit from behind, not wearing a seatbelt. Airbags deployed as she hit trees on the side of the road. She was complaining mostly of head and cervical pain, crying hysterically.

On Dr. advised he saw the claimant for pain over the neck, back and left knee following a motor vehicle accident on as an unrestrained driver, a mail carrier that was rear-ended as she was ending her route and turning right into the post office. She was having headaches and neck pain. Her airbag did deploy and she felt the movement of impact when her mail carrier vehicle moved to the side of the road and hit small tress. CT of the cervical spine, head and brain were negative. She was stiff and sore. She had been given medicine in the ER but was not currently taking medication for pain. She denied any new injuries or falls. The claimant was advised to rest another week before starting PT. Dr. provided his assessment: driver injured in collision with unspecified vehicle in traffic accident; cervicalgia; left knee pain; low back pain; and body mass index (BMI) 36.

Om Dr. indicating the claimant was still having neck/back and left knee pain with no improvement or worsening since the accident. She had difficulty sleeping. Medication was not significantly helping her pain. She had a constant sharp/stabbing pain down the lower back and sharp pain in the neck turning to the side. There was no radiculopathy down the arms or legs, no numbness, weakness, tingling bowel/bladder incontinence. She did not have left knee imaging yet. There were no changes after 2 weeks of conservative therapy. He prescribed vitamins, pain medication and gave a referral for physical therapy, orthopedic spine evaluation and second opinion. Diagnostic imaging of the lumbosacral spine was also ordered. Dr. provided his assessment: driver injured in collision with unspecified vehicle in traffic accident; cervicalgia; left knee pain; low back pain; and body mass index (BMI) 36.

, Dr. noted the claimant was seen for persistent neck and right arm pain and low back and leg pain that began after she was involved in a rear-ended motor vehicle accident while at work on delivering mail. She never had similar symptoms before. She was taken by ambulance from the scene to the emergency room. X-rays showed no fractures or dislocations. She was treated with pain medications, muscle relaxers with no

improvement. Neck pain was more on the right side and down to the right arm, with no clear dermatomal pattern. She reported intermittent numbness and intermittent weakness of the right arm. Daily pain score was 7/10 significantly affecting activities of daily living. Lower back pain was mostly on the left. She noticed intermittent left leg symptoms predominantly in the L4 nerve root distribution. Daily pain score was 8/10, significantly worse with any activity, walking and standing, somewhat better with rest. She noticed intermittent numbness and weakness in the left leg. She was not able to return to work since Cervical spine CT scan showed mild spondylitic changes but no clear neural compromise. Cervical spine x-rays showed mild spondylitic changes but no clear evidence of spondylolisthesis. Lumbar spine x-rays showed mild spondylitic changes but no evidence of spondylolisthesis. Lumbar and cervical MRI studies were ordered to determine further management, to evaluate for potential herniations and in anticipation of injection therapy or surgical interventions. The claimant was advised to stay off work. Physical therapy and pain medications were recommended. The following diagnoses were given: spondylosis without myelopathy or radiculopathy, lumbosacral region; intervertebral disc disorders with radiculopathy, lumbosacral region; cervical disc disorder, unspecified, cervico-thoracic region; and cervicalgia

On , Dr. advised a new lumbar spine MRI showed left central disc protrusion at L5-S1 in close proximity to left 51 nerve root, mild to moderate facet arthropathy, but otherwise no clear neural compromise. A new cervical spine MRI showed central disc protrusion at C3-4, C4-5 and C5-6, diffuse disc/osteophyte at C6-7 with mild foraminal narrowing at this level. Majority of pain was in the low back and down left leg, mostly an S1 nerve root distribution. Pain was continuous and significantly worse with activities, pain score 8/10, significantly interfering with activities of daily living as well as sleep. Cervical spine pain was predominantly on the right side and down right arm, no clear dermatomal pattern. Dr. explained that, clinically, there was acute low back, leg and neck and right arm pain after a motor vehicle accident while at work. The majority of low back and left leg pain appeared to be secondary to disc protrusion at L5-S1. Recommendation was for L5-S1 epidural steroid injection under fluoroscopic guidance and physical therapy for her neck and right arm symptoms, consider C5-C7 epidural injection and right upper extremity EMG/nerve conduction study. She was advised to continue off work for another 6 weeks and continue medications. She was about to start physical therapy. The following diagnoses were given: intervertebral disc disorders with radiculopathy, lumbar region; radiculopathy, lumbar region; radiculopathy, cervical region; cervicalgia.

On , Dr. noted the claimant was seen for follow-up for work-related injury in of last year. She started physical therapy, 2 sessions so far, and noticed some improvement with range of motion In neck and lower back area. She had lumbar epidural steroid injection under fluoroscopic guidance 7 days ago, noticed some improvement of low back and left leg pain. Unfortunately, she still had persistent neck and right arm as well as low back and left leg pain, continuous and significantly worse with activities, pain score 7/10, significantly interfering with activities of daily living and sleep. She was not able to work since She noted only minimal improvement taking hydrocodone. She would be scheduled for right upper and left lower extremity EMG nerve conduction study an given a muscle relaxant to take 3 times a day. She would also will continue physical therapy. Depending on the response, further management would be determined. The following diagnoses were given: spondylosis without myelopathy or radiculopathy, lumbar region; low back pain; other spondylosis, cervical region; Other spondylosis with myelopathy, cervical region; cervicalgia.

On Dr. , MD noted the claimant had persistent predominantly axial low back pain that developed after an injury at work in of last year, extensive physical therapy with only minimal improvement, pain score 7/10, significantly interfering with activities of daily living, not able to return to regular activities secondary to severe pain. Lumbar spine MRI showed mild/moderate facet arthropathy at L4-5 and L5-51 level and minimal degenerative disease, but no clear neural compromise. She still had persistent neck pain, no significant help from epidural injection. Right upper and left lower EMG nerve conduction study was normal and showed no electrodiagnostic evidence of radiculopathy or neuropathy. Treatment would be bilateral L4-5 and L5-S1 facet joint injection under fluoroscopic guidance. Depending on response, a trial of medial branch nerve block with rhizotomy was possible. Diagnosis was: spondylosis without myelopathy or radiculopathy, lumbar region; Low back pain; Pain in right shoulder; Other spondylosis, cervical region.

On , Dr. noted the claimant had persistent predominantly axial low back pain, continuous and significantly worse with activities, daily pain score 7/10, taking Tylenol, Skelaxin and meloxicam. She overall noticed some improvement with taking those medications, able to tolerate those well without any significant side effects. Lumbar spine MRI showed mild/moderate facet arthropathy and lumbar spine, but no clear neural compromise. She was advised to continue home stretching and strengthening exercises and continue medications with facet joint injections in several months, as planned.

On Dr. noted the claimant had persistent predominantly axial low back pain that started after she was involved in an accident at work, extensive physical therapy recently. She noticed slightly improved range of motion lumbar spine, but no significant change with pain level. The majority of pain was in her low back and across her back, 90% in low back and 10% in left proximal leg. Pain was continuous and significantly worse with activities, daily numeric rating 7/10, interferes with activities of daily living as well as sleep. Lumbar spine MRI showed spondylitic changes at L4-5 and L5-S1, most limited with moderate/severe facet arthropathy, but no clear neural compromise. She had been taking meloxicam and Tylenol with minimal help. She tried tramadol in the past with no significant help. Majority of pain was facetogenic. She would be scheduled for diagnostic bilateral medial branch nerve block without steroids at L4-5 and L5-S1 and was advised to continue home stretching and strengthening exercises

On Dr. noted the claimant was seen for persistent low back pain 8/10 interfering with sleep and activities since when she was driving her mail truck and was rear-ended by another car. She noticed immediate persistent low back pain, which progressed. She never had similar symptoms before. Extensive PT and home stretching did not help. Lumbar spine MRI showed mild/moderate facet arthropathy at L4-5 and L5-S1 predominantly, with no clear neural compromise. She had bilateral medial branch nerve blocks at L4-5 and L5-S1 facet joints reporting 60% pain improvement and improved ROM lasting 36 hours, then the pain recurred. She was no able to return to work due to pain and was advised to stay off work until treatment was completed. Dr. opined that the motor vehicle accident caused the low back pain and disability, secondary to facet joint mediated pain. She would be scheduled for a second diagnostic medial branch nerve block at L4-5 and L5-S1. She would remain off work. Diagnosis was spondylosis without myelopathy or radiculopathy, lumbar region.

Based on my careful consideration of the evidence of record at this time, I find that the decision dated should be set aside. Based on submission of new evidence on appeal, the claim is not in posture for a decision at this time. Additional development of the medical evidence is warranted before a decision on this matter is rendered.

A claimant seeking benefits under the FECA has the burden of proof to establish the essential elements of his or her claim. When the claimant alleges an injury in the performance of duty, the claimant must submit sufficient evidence to establish that he or she experienced a specific event, incident or exposure occurring at the time, place and in the manner alleged. The claimant must also establish that such event, incident or exposure caused an "injury" as defined in the Act and its regulations.[1] The term "injury" as defined by the FECA refers to some physical or mental condition caused by trauma or repeated exposure to, or contact with, certain factors, elements, or conditions.[2]

Second, the employee must submit sufficient evidence, generally only in the form of medical evidence, to establish a causal relationship between the employment incident and the alleged disability and/or condition for which compensation is claimed. An employee may establish that the employment incident occurred as alleged, but fail to show that his or her disability and/or condition relates to the employment incident.[3]

In this case, the claimant works as a for the She alleged that she was injured at work on due to a motor vehicle accident when she was in her vehicle stopped while returning from her delivery route, with her turn signal on, waiting to turn into the driveway of the post office and her vehicle was rear-ended. The claimant alleged she sustained a severe concussion, pain in the left side of her neck, shoulder pain, severe pain in the lower back and left knee due to the accident. A copy of the accident report from the incident of was received to the record. confirmed that the incident took place as alleged and the claimant was in the performance of duty when it occurred.

The initial medical records show the claimant was taken by ambulance from the accident scene to the Emergency Room, where she was evaluated for cervical sprain and concussion and underwent CT studies of the brain and cervical spine. On Dr. advised the claimant was disabled from work for at least one month due to back pain, neck pain and radiculopathy and referred her for x-rays of the spine. On Dr. indicated the claimant would be unable to work for 6 to 8 weeks due to severe muscle, arm and lower back pain and referred her for physical therapy.

The claim was denied by the District Office with a finding that the medical evidence was insufficient to establish Fact of Injury as no physician had offered a firm diagnosis of any medical condition in connection with the work incident of .. Additionally, no physician had provided a medical opinion supporting a causal relationship between the established work incident and any diagnosed condition.

I find the decision of the District Office was correct, based on the evidence of record at the time of adjudication. Almost all of the medical evidence received with the initial claim consisted of work excuse slips. Although some were signed by physicians, none of these documents contained any discussion of the work incident of The After Visit Summary from the emergency room was not a medical report, as it was not signed by a physician. It has no probative value under the Act. It is well established that a physician's signature is required

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[1] *Melissa A. Carter*, 45 ECAB 618 (1994.)
[2] *Christine S. Hebert*, 49 ECAB __ (Docket No. 96-812, issued August 4, 1998.)
[3] *Gary J. Watling*, 52 ECAB 278 (2001); *Shirley A. Temple*, 48 ECAB 404, 407 (1997).

on a report in order for it to be considered as medical evidence.[4] Additionally, most of the work excuse slips indicated the claimant was disabled from pain. The Board has consistently held that pain is a symptom, rather than a compensable medical diagnosis.[5]

On appeal, a significant amount of medical treatment records were provided from the claimant's treating physicians, discussing the medical findings and providing a firm diagnosis in connection with the work incident of Additionally, diagnostic testing reports were received for further evaluation of the claimant's condition including CT of the head and cervical spine; MRI of the lumbar spine; MRI of the cervical spine and EMG/Nerve conduction studies.

The progress notes from the Emergency Room by Dr. advised that the claimant was seen for concussion and sprain of trapezium following a motor vehicle accident that day when she was pulling into the post office and was hit from behind, not wearing a seatbelt. Airbags deployed as she hit trees on the side of the road. She was complaining mostly of head and cervical pain, crying hysterically.

In his office notes of anc discussed the medical findings including and gave his assessment of driver injured in collision with unspecified vehicle in traffic accident; cervicalgia; left knee pain; low back pain; and body mass index (BMI) 36 noting headaches and back pain following a motor vehicle accident on as an unrestrained driver, a mail carrier that was rear-ended as she was ending her route and turning right into the post office.

In his numerous office notes from through Dr. discussed an accurate history of injury and medical findings on examination and objective testing results. Dr. noted the claimant was seen for persistent neck and right arm pain and low back and leg pain that began after she was involved in a rear-ended motor vehicle accident while at work on delivering mail. She never had similar symptoms before. Lumbar MRI showed left central disc protrusion at L5-S1 in close proximity to left 51 nerve root, mild to moderate facet arthropathy, but otherwise no clear neural compromise. Cervical MRI showed central disc protrusion at C3-4, C4-5 and C5-6, diffuse disc/osteophyte at C6-7 with mild foraminal narrowing at this level. Dr. explained that, clinically, there was acute low back, leg and neck and right arm pain after a motor vehicle accident while at work. The majority of low back and left leg pain appeared to be secondary to disc protrusion at L5-S1. Right upper and left lower EMG nerve conduction study was normal and showed no electrodiagnostic evidence of radiculopathy or neuropathy.

These new reports provided by the claimant's physicians on appeal provide several firm diagnoses in connection with the established work incident of As the work incident has been established as factual and a firm diagnosis has been provided by a physician, the standard for Fact of Injury has now been met. I also find the evidence is sufficient to establish that the claimant was in the performance of duty when the incident occurred.

An employee who is on a trip for his employer is under the protection of the FECA while engaging in activities essential to or reasonably incidental to these special activities. However, when the employee deviates from the activities incidental to his employment, he ceases to be within the protection of the Act and an injury occurring during such deviation is not compensable. An identifiable deviation from a business trip for personal reasons takes the

[4] *B.M.*, Docket No. 11-725 (issued February 17, 2012).
[5] *C.F.*, Docket No. 08-1102 (issued October 10, 2008).

employee out of the course of his employment until he returns to the route of the business trip unless the deviation is so insubstantial that it may be disregarded. In his discussion on deviation from a prescribed work-related route, Larson notes that the majority view is that a side trip for personal reasons remains a deviation until completed, that is, until the main work-related route is regained.[6]

In this case, the claimant was returning from her assigned route as a uring her work shift and was arriving to the post office when the accident occurred. There is no evidence to suggest the claimant had any deviation from her assignment. The other driver was cited for the accident, according to the who confirmed the claimant was in the performance of duty.

The remaining issue for the claim is whether the medical evidence of record is sufficient to establish causal relationship under the requirements of the FECA.

A person who claims benefits under the FECA has the burden of establishing the essential elements of his or her claim. The claimant has the burden of establishing by the weight of reliable, probative and substantial evidence that the condition for which compensation is sought is causally related to a specific employment incident or to specified conditions of the employment. As part of this burden, the claimant must present rationalized medical opinion evidence based upon a complete factual and medical background showing causal relationship. The mere fact that a condition manifests itself or is worsened during a period of employment does not raise an inference of causal relationship between the two. Such a relationship must be shown by rationalized medical evidence of causal relation based upon a specific and accurate history of employment incidents or conditions which are alleged to have caused or exacerbated a disability.[7]

I find the reports from the claimant's physicians submitted on appeal do not contain sufficient medical reasoning to meet the burden of proof under the requirements of the FECA. Although these physicians have discussed the work incident and made several diagnoses that appear to be linked to it, no physician of record has given a clear, reasoned opinion explaining how the work incident of caused or contributed to any diagnosed condition.

Although these new reports are not sufficient to accept the claim, I find the claimant's physicians on appeal have provided sufficient medical opinions to warrant further development of the medical evidence before a decision on the claim is reached. Medical reports have been received with opinions based on an accurate history of injury, based on direct examination of the claimant, review of the objective medical findings and diagnostic test results, with firm diagnoses made in connection with the established work incident. The diagnoses provided by the claimant's physicians are consistent with the nature of the injury and the claimed medical conditions.

Although the claimant's physicians have not offered sufficient medical reasoning to meet the claimant's burden of proof, they have raised an uncontroverted inference of causal relationship. This is substantial evidence in support of the claim, which has not been contradicted by any

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[6] *Katherine A. Kirtos*, 42 ECAB ___ (Docket No. 90-0946, issued October 31, 1990).

[7] *Steven R. Piper,* 39 ECAB ___ (1987); *Nino V. DiGrezio*, 39 ECAB ___ (1988); *Jill Thimmesch*, 39 ECAB ___ (1988); *Johnson K. Yazzie*, 39 ECAB ___ (1988); *Earl D. Price*, 39 ECAB ___ (1988); *Orlando Vivens*, 39 ECAB ___ (1988); *Lawrence E. Bennett*, 39 ECAB ___ (1988); *Michael Stockert*, 39 ECAB ___ (1988); *Velta H. Mikelsons*, 39 ECAB ___ (1988); *Richard F. Hines*, 39 ECAB ___ (1988).

other physician of record. The medical evidence of record is therefore sufficient to require further development of the case record by the Office.[8]

Proceedings under the Federal Employees' Compensation Act are not adversarial in nature, and the Office is not a disinterested arbiter.[9] While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence and the Office has an obligation to see that justice is done.[10]

The non-adversarial policy of proceedings under FECA is reflected in the regulations at section 10.121.[11] When all evidence has been gathered from the attending physician and there is not enough evidence regarding diagnosis or an adequately reasoned opinion about causal relationship to accept the case, but there is sufficient evidence to suggest that the claimant might be entitled to benefits, the claimant should be referred to a second opinion physician.[12]

Upon return of the case file record to the District Office, a Statement of Accepted Facts (SOAF) should be composed; and the claimant should be referred to an appropriate medical specialist for a directed "second opinion" examination, to provide a rationalized opinion addressing whether the claimant sustained a work-related injury as alleged.[13] The Office provides a physician with a SOAF to assure that the medical specialist's report is based upon a proper factual background.[14] The SOAF must include the date of injury, claimant's age, the job held on the date of injury, the employer, the mechanism of injury and the claimed or accepted conditions.[15]

The second opinion physician should also receive copies of the medical evidence of record to review prior to the examination, including diagnostic studies, treatment records and office notes from the attending physicians.

The second opinion physician should discuss the history of injury according to the SOAF and available records; conduct a thorough examination; provide his or her own detailed subjective and objective examination findings; discuss the objective test results; and provide a firm diagnosis for medical conditions affecting the claimant following the work incident of The second opinion physician should discuss the work incident and any pre-existing conditions, then provide a rationalized medical opinion explaining whether the work incident caused or contributed to any diagnosed medical condition by direct causation, aggravation, acceleration, precipitation or otherwise.

If the second opinion physician believes a pre-existing condition was in some way aggravated, accelerated or in any other way affected by the work incident, the rationalized medical opinion must include a discussion of the nature of the underlying conditions; their natural or traditional course; how the underlying conditions may have been affected by federal work duties as

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[8] *John J. Carlone*, 41 ECAB 354 (1989); *Horace Langhorne*, 29 ECAB 820 (1978).
[9] *Betty J. Smith*, 54 ECAB ___ (Docket No. 02-149, issued October 29, 2002).
[10] *See Phillip L. Barnes*, 55 ECAB ___ (Docket No. 02-1441, issued March 31, 2004); *Lourdes Davila*, 45 ECAB 139 (1993).
[11] 20 C.F.R. § 10.121.
[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluation Medical Evidence*, Chapter 2.810.9(b)(1) (June 2015).
[13] *Robert J. Pitchford*___ECAB Docket 03-1415, Issued August 8, 2003.
[14] *Helen Casillas*, 46 ECAB 1044 (1995).
[15] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Statements of Accepted Facts*, Chapter 2.809.12 (June 1995); *see also Darletha Coleman*, 55 ECAB ___ (Docket No. 03-868, issued November 10, 2003).

determined by medical records covering the period of employment; whether such affects, if any, caused material changes in the underlying conditions; or, if no material changes occurred, would the symptoms or changes indicative of a temporary aggravation have subsided or resolved immediately upon appellant's removal from the employment environment; or if not, at what point would such symptoms or changes have resolved. The physician should explain whether work-related aggravation of underlying conditions caused disability from work during any time period.[16]

The second opinion physician should be reminded that, under the FECA, it is not necessary to prove a significant contribution of factors of employment to a condition for the purpose of establishing causal relation. If the medical evidence reveals that an employment factor contributes in any way to the employee's condition, such condition would be considered employment related for purposes of compensation under the Act.[17] Where the medical evidence supports an aggravation or acceleration of an underlying condition precipitated by working conditions or injuries, such disability is compensable.[18] However, the normal progression of untreated disease cannot be stated to constitute aggravation of a condition merely because the performance of normal work duties reveals the underlying condition.[19]

If the second opinion physician finds the claimant sustained a work-related injury, he or she should explain whether the work-related medical condition(s) persist; of if the work-related injury has resolved. The second opinion physician should explain whether any medical treatment is needed for the work-related conditions. Any period(s) of disability due to a work-related medical condition should be identified.

The second opinion physician should provide medical reasoning to support his or her medical opinions; and provide a discussion of any supportive evidence.

Once the second opinion physician's report is received, the District Office should undertake any additional development of the evidence such as it finds warranted, and issue a *de novo* decision on the issue of whether the evidence is sufficient to establish a work-related injury, as alleged.

For the reasons set forth above, the decision dated is hereby set aside, and the case is remanded to the District Office for actions consistent with this decision.

Issued:
Washington, D.C.

Electronically Signed (DSL)
Hearing Representative
Branch of Hearings and Review
for
Director, Office of Workers'
Compensation Programs

[16] *Newton Ky Chung*, 39 ECAB ___ (1988).
[17] *Arnold Gustafson*, 41 ECAB ___ (Docket No. 89-0438 issued October 30, 1989).
[18] *A.C.*, Docket No. 08-1453 (issued November 18, 2008).
[19] *Glenn C. Chasteen*, 42 ECAB 493 (1991).