# United States Department of Labor
# Employees' Compensation Appeals Board

| | | |
|---|---|---|
| **R.D., Appellant** | ) | |
| **and** | ) | **Docket No. 10-1821** |
| | ) | **Issued: April 11, 2011** |
| **DEPARTMENT OF DEFENSE, DEFENSE COMMISARY AGENCY, Lemoore, CA, Employer** | ) | |

*Appearances:*
*Norman R. McNulty, Jr., Esq.*, for the appellant
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
RICHARD J. DASCHBACH, Chief Judge
ALEC J. KOROMILAS, Judge
COLLEEN DUFFY KIKO, Judge

### ***JURISDICTION***

On July 1, 2010 appellant filed a timely appeal from the Office of Workers' Compensation Programs' April 8, 2010 merit decision denying her occupational disease claim. Pursuant to the Federal Employees' Compensation Act[1] and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

### ***ISSUE***

The issue is whether appellant sustained a neck/shoulder condition as a result of employment activities.

On appeal, counsel contends that the medical evidence of record is sufficient to establish that she sustained an injury as a result of her employment activities.

[1] 5 U.S.C. § 8101 *et seq.*

## ***FACTUAL HISTORY***

On February 11, 2008 appellant, then a 50-year-old store associate, filed an occupational disease claim alleging that she developed right shoulder pain as a result of employment activities. She submitted a February 15, 2008 disability slip from Dr. V. Randy Bernabe, a Board-certified osteopath specializing in orthopedic surgery, reflecting that she was unable to work from February 21 through March 10, 2008.

On February 25, 2008 the employing establishment controverted the claim, contending that appellant had failed to establish that she sustained an injury as a result of her employment duties. It also argued that pain was not an appropriate diagnosis.

By letter dated March 2, 2008, the Office informed appellant that the evidence submitted was insufficient to establish that she sustained an injury as a result of employment activities. Appellant was advised to submit additional information and evidence, including a physician's report, which contained a diagnosis and explanation as to how her diagnosed condition resulted from the claimed employment activities.

On March 25, 2008 appellant stated that the pain had been continuous and had increased over the previous two years and now included aches, pains and numbness in both shoulders, as well as her arms, neck and back. She described her work duties, which allegedly caused her neck and shoulder condition. Appellant's nightly responsibility for maintaining the milk cooler required her to move, lift and stack milk crates to a "6-high" level, often necessitating that she turn and reach overhead to restock. Palletizing frozen merchandise in freezers required pushing and pulling heavy loads weighing up to 70 pounds. Cleaning, rearranging and general stocking of shelves required her to climb up and down a ladder 7 to 8 hours a day during a 36- to 39-hour workweek.

In reports dated April 1, 2008, Dr. John M. Riddle, a treating physician, diagnosed cervical radiculitis. He noted that appellant worked in freezers, lifting heavy milk crates. Examination revealed that she could rotate her neck only 10 degrees to the right. Dr. Riddle indicated by placing a checkmark in the "yes" box that he believed appellant's condition to be caused or aggravated by employment factors. He stated that "lifting motion of heavy objects could have caused impingement."

In a decision dated April 18, 2008, the Office denied appellant's claim on the grounds that the evidence was insufficient to establish that her diagnosed conditions were caused by established work-related events.[2] On March 25, 2009 appellant requested reconsideration.

Appellant submitted a February 1, 2008 report from Dr. Bernabe. He stated that appellant had been experiencing bilateral shoulder pain, posterior neck pain and numbness and tingling in her upper extremities for approximately eight years while working as a grocery stocker, lifting up to 70 pounds every day, five days a week. An MRI scan of the cervical spine showed multilevel degenerative disc disease. Examination of her bilateral shoulders showed a

[2] The record reflects that appellant requested an oral hearing on May 13, 2008. She withdrew her request on August 5, 2008.

negative two-finger drop test and a negative subscapularis lift-off test. Range of motion examination revealed 120 degrees of forward flexion and 90 degrees of abduction. There was significant pain on palpation along the spinous process of the posterior cervical spine from the C2 to T1 region, with decreased side bending, rotation, flexion and extension, with a positive Spurling's test. Dr. Bernabe diagnosed multilevel cervical degenerative disc disease with cervical spinal stenosis. In a March 6, 2008 attending physician's report, he indicated by placing a checkmark in the "yes" box his belief that appellant's diagnosed multilevel cervical degenerative disc disease with cervical spinal stenosis was caused or aggravated by employment activities.

Appellant submitted a December 12, 2007 report from Dr. Martin Rindahl, a Board-certified radiologist. On examination of the cervical spine, Dr. Rindahl found no gross deformities and mild, diffuse paraspinous tenderness. He diagnosed severe degenerative changes of the neck with spinal stenosis.

Appellant submitted reports from Dr. Donald Meyers, a treating physician, for the period September 8, 2008 to April 22, 2009. On September 22, 2008 Dr. Meyers diagnosed C5-6 radiculopathy and described appellant's history of cervical pain, noting that she began having cervical problems two years earlier while doing heavy work and pulling a pallet. In the course of time, appellant developed problems with her neck and lower back and, in February 2008, was unable to use her right arm and shoulder due to severe pain. Sensory testing showed C5-6 hypoesthesia on the right side. There was also tenderness on the biceps and quadriceps muscles on the right side. An MRI scan of the cervical spine showed multilevel degenerative changes with a slight reversal of curvature, which was worse at the C5-6 level. There was a modest C5-6 disc protrusion with some degree of foraminal stenosis. Appellant demonstrated significant pain in and about her shoulder with impingement and tenderness in the bicipital tendon. Dr. Myers stated that it was "likely that her problem [was] coming primarily from her neck as the upper rhomboid spasm at the C5-6 level with the right combined with the C5-6 hypoesthesia and tenderness in the biceps muscle on the right, all tend to suggest C5-6 acute radiculopathy."

On November 4, 2008 Dr. Myers recommended C5-6 anterior discectomy and fusion, which he performed on February 14, 2009. On February 27, 2009 he opined that appellant was totally disabled and had been disabled since February 2008. The record also contains diagnostic test results, including October 17, 2007 and June 10, 2008 reports of MRI scans of the cervical spine and a February 13, 2009 report of a computerized tomography (CT) scan of the cervical spine.

By decision dated June 17, 2009, the Office denied modification of its April 18, 2008 decision. On January 20, 2010 appellant again requested reconsideration, contending that new medical evidence established that appellant sustained a shoulder injury in the performance of duty.

In support of her reconsideration request, appellant submitted a December 7, 2009 report from Dr. John W. Ellis, a Board-certified osteopath specializing in family medicine. Dr. Ellis described appellant's work activities, which required her to repetitively scan items. Appellant's duties maintaining the milk cooler consisted of moving and stacking milk crates up to six crates high, turning to reach overhead to uncrate and crate to restock milk racks on a nightly basis. She

also was required to break down frozen merchandise in the freezers, a task which required a lot of pushing, pulling cases weighing up to 70 pounds, reaching overhead and moving side to side. In 2006, appellant began to experience pain in the back of her neck, between her shoulders, and in the proximal shoulder joints, as well as some numbness down her arms. She continued to experience severe pain in her neck and shoulders following a February 12, 2009 C5-6 anterior cervical discectomy and fusion.

Examination of the right shoulder revealed tenderness of the AC joint, biceps tendon and supraspinatus muscle. Gentle pressure on the trapezius muscle reproduced tingling down the right arm, and there was crepitation and audible and palpable popping, as well as decreased range of motion of the right shoulder, especially on internal rotation. Examination of the left shoulder revealed tenderness of the AC joint, but with full range of motion. Examination of the right elbow showed hypertrophy and tenderness over the medial epicondyle. Tinel's sign was positive over the cubital tunnel, but not the radial tunnel, with decreased range of motion. Examination of the left elbow revealed no tenderness over the medial or lateral epicondyle. Examination of the right hand revealed a positive Finkelstein's test, with a positive Tinel's sign over the median and ulnar nerves at the right hand. There was decreased range of motion and grip strength of the right hand. Examination of the left hand reveals decreased grip strength Examination of the back reveals tenderness over the iliolumbar and sacroiliac ligaments.

Dr. Ellis found decreased sensation on the chest and abdomen, greater on the right side, as well as in the upper and lower extremities, greater on the right side. Reflexes were 2+ and equal in the biceps and triceps, but absent in the wrists. Dr. Ellis found no evidence of symptom magnification or malingering.

Due to repetitive work at the employing establishment, Dr. Ellis diagnosed: muscle tendon unit strains of the neck and back; deranged discs in the neck and back; herniated disc at C5-6 requiring fusion; bilateral cervical radiculopathy; right L5 and S1 nerve root impairment; left S1 nerve root impairment; repetitive strains of the shoulders with traumatic arthritis and internal derangement of the right shoulder; bilateral brachial plexus impingement; right medial epicondylitis with cubital tunnel syndrome; right carpal tunnel syndrome; and de Quervain's stenosing tenosynovitis of the right wrist.

Dr. Ellis opined, to reasonable medical certainty, that appellant's work duties contributed to, aggravated and/or caused appellant's diagnosed conditions. Appellant's repetitive scanning caused the muscles and ligaments in her neck, shoulders, upper back, lower back, shoulder joints, elbows and wrists to become hypertrophied and thickened. Due to her short stature (four feet, nine inches), stocking merchandise caused repetitive strains in the neck, shoulder girdles, upper and lower back. The strains caused increased pressure on the cervical discs in the neck, which in turn caused impingement of the cervical nerves down her upper extremities. Once the cervical nerves were impinged, then all of the nerves in her upper extremities became very sensitive to any hypertrophy in her right elbow and right hand, resulting in right cubital tunnel syndrome and right carpal tunnel syndrome. Appellant's lifting and storing merchandise caused strains and tears of the ligaments and joint in her right shoulder, causing internal derangement and traumatic arthritis of the right shoulder. The tightness in her neck and shoulder girdles from her neck and shoulder injuries caused the muscles and ligaments external to the cervical spine to impinge the brachial plexus of nerves down her arms. The injuries to her back caused

impingement of the nerves from the spine down into her legs. It also caused tightness and strains of her buttocks with bilateral lumbosacral plexus impingement. Dr. Ellis explained that once any part of the nervous system has been impinged, the other nerves in the extremities become more sensitive to impingement, resulting in a condition known as double crush syndrome. He opined that appellant was temporarily and totally disabled as a result of her work-related activities. Dr. Ellis stated: "But for her work at [the employing establishment, [appellant] would not be having the problems in her neck, shoulder, back, right elbow and right wrist that are occurring."

By decision dated April 8, 2010, the Office denied modification of its prior decision, finding that the medical evidence did not support that appellant had a diagnosed condition causally related to accepted work factors. It found that Dr. Ellis failed to provide rationale for his opinion on causal relationship.

## ***LEGAL PRECEDENT***

An employee seeking benefits under the Act[3] has the burden of establishing the essential elements of his or her claim including the fact that the individual is an employee of the United States within the meaning of the Act, that the claim was timely filed within the applicable time limitation period of the Act, that an injury was sustained in the performance of duty as alleged, and that any disability and/or specific condition for which compensation is claimed are causally related to the employment injury.[4] These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[5]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, a claimant must submit the following: (1) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; (2) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; and (3) medical evidence establishing that the employment factors identified by the claimant were the proximate cause of the condition for which compensation is claimed or, stated differently, medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the claimant.

The medical evidence required to establish causal relationship, generally, is rationalized medical opinion evidence. Rationalized medical opinion evidence is medical evidence which includes a physician's rationalized opinion on the issue of whether there is a causal relationship between the claimant's diagnosed condition and the implicated employment factors. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[6] However, it is well established that

[3] 5 U.S.C. §§ 8101-8193.

[4] *Joe D. Cameron*, 41 ECAB 153 (1989); *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

[5] *Victor J. Woodhams*, 41 ECAB 345 (1989).

[6] *Id*.

proceedings under the Act are not adversarial in nature and while the claimant has the burden of establishing entitlement to compensation, the Office shares responsibility in the development of the evidence to see that justice is done.[7]

## ***ANALYSIS***

The Board finds that this case is not in posture for a decision on whether appellant sustained a shoulder injury as a result of her employment activities. The Office accepted that she was engaged in employment duties, as alleged. It denied her claim, however, on the grounds that the evidence failed to establish a causal relationship between those activities and her diagnosed neck and shoulder conditions. The Board finds that the medical evidence of record supports a causal relationship between appellant's work activities and her neck and shoulder conditions.

On December 7, 2009 Dr. Ellis diagnosed muscle tendon unit strains and deranged discs in the neck and back; a herniated disc at C5-6; bilateral cervical radiculopathy; right L5 and S1 nerve root impairment; left S1 nerve root impairment; repetitive strains of the shoulders with traumatic arthritis and internal derangement of the right shoulder; bilateral brachial plexus impingement; right medial epicondyitis with cubital tunnel syndrome; right carpal tunnel syndrome; and de Quervain's stenosing tenosynovitis of the right wrist. He provided detailed examination findings in support of his diagnoses and accurately described appellant's work activities, which he opined, to reasonable medical certainty, contributed to, aggravated and/or caused appellant's diagnosed conditions. Dr. Ellis explained that repetitive scanning caused the muscles and ligaments in her neck, shoulders, upper back, lower back, shoulder joints, elbows and wrists to become hypertrophied and thickened. Due to appellant's short stature (four feet, nine inches), stocking merchandise caused repetitive strains in the neck, shoulder girdles, upper and lower back. The strains caused increased pressure on the cervical discs in the neck, which in turn caused impingement of the cervical nerves down her upper extremities. Once the cervical nerves were impinged, then all of the nerves in appellant's upper extremities became very sensitive to any hypertrophy in her right elbow and right hand, resulting in right cubital tunnel syndrome and right carpal tunnel syndrome. Her lifting and storing merchandise caused strains and tears of the ligaments and joint in her right shoulder, causing internal derangement and traumatic arthritis of the right shoulder. The tightness in appellant's neck and shoulder girdles from her neck and shoulder injuries caused the muscles and ligaments external to the cervical spine to impinge the brachial plexus of nerves down her arms. The injuries to her back caused impingement of the nerves from the spine down into her legs. It also caused tightness and strains of appellant's buttocks with bilateral lumbosacral plexus impingement. Dr. Ellis explained that once any part of the nervous system has been impinged, the other nerves in the extremities become more sensitive to impingement, resulting in a condition known as double crush syndrome. He concluded that, "but for" her work at the employing establishment, appellant would not be experiencing her current symptoms. Although Dr. Ellis did not fully explain how appellant's employment activities were competent to cause each of her diagnosed conditions, his

[7] *Phillip L. Barnes*, 55 ECAB 426 (2004); *see also Virginia Richard*, 53 ECAB 430 (2002); *Dorothy L. Sidwell*, 36 ECAB 699 (1985); *William J. Cantrell*, 34 ECAB 1233 (1993).

report strongly supports a causal relationship between the identified activities and the diagnosed neck and shoulder conditions.

On April 1, 2008 Dr. Riddle provided examination findings and diagnosed cervical radiculitis. He described appellant's work activities and noted with a checkmark that he believed that appellant's condition was caused or aggravated by employment factors. Dr. Riddle opined that lifting heavy objects could have caused impingement. He provided a specific diagnosis and identified the employment factors believed to have caused or contributed to appellant's condition. Although his report lacks a full explanation as to how appellant's lifting activities caused or contributed to her condition,[8] it does support a causal relationship between the cervical condition and the established activities.

Similarly, Dr. Bernabe described the development of appellant's bilateral shoulder pain, posterior neck pain and numbness and tingling in her upper extremities over an eight-year period while working as a grocery stocker, lifting up to 70 pounds every day, five days a week. He provided detailed examination findings and diagnosed multilevel cervical degenerative disc disease with cervical spinal stenosis. On March 6, 2008 Dr. Bernabe indicated by placing a checkmark in the "yes" box his belief that appellant's diagnosed condition was caused or aggravated by employment activities. As his report does not contain an explanation as to how appellant's employment activities were causally related to the diagnosed condition, it is insufficient to establish her claim.[9] It does, however, strongly suggest a causal connection between the work activities and the diagnosed condition.

On December 12, 2007 Dr. Rindahl reported examination findings and diagnosed severe degenerative changes of the neck with spinal stenosis. On September 22, 2008 Dr. Meyers described the development of appellant's neck and shoulder condition, provided examination findings and diagnosed C5-6 radiculopathy. After performing C5-6 anterior discectomy and fusion in February 2009, he opined that appellant was totally disabled. These reports do not contain an opinion as to the cause of appellant's diagnosed cervical condition and, therefore, are of limited probative value. They do, however establish that she was diagnosed and treated for a cervical condition during the applicable period of time.

The Board notes that, while none of the reports of appellant's attending physicians are completely rationalized, they are consistent in indicating that she sustained an employment-related cervical and shoulder condition, and are not contradicted by any substantial medical or factual evidence of record. While the reports are not sufficient to meet her burden of proof to establish her claim, they raise an uncontroverted inference between appellant's diagnosed condition and the identified employment factors and are sufficient to require the Office to further develop the medical evidence and the case record.[10] The case will be remanded to the Office to

[8] A mere checkmark or affirmative notation in response to a form question on causal relationship is not sufficient to establish a claim. *See Gary J. Watling*, 52 ECAB 278 (2001).

[9] Medical conclusions unsupported by rationale are of little probative value. *Willa M. Frazier*, 55 ECAB 379 (2004).

[10] *See Virginia Richard*, 53 ECAB 430 (2002); *see also Jimmy A. Hammons*, 51 ECAB 219 (1999); *John J. Carlone*, 41 ECAB 354 (1989).

obtain a rationalized opinion from a qualified physician as to whether appellant's shoulder and cervical conditions are causally related to the identified work activities. After such development as it deems necessary, the Office should issue an appropriate decision in order to protect appellant's rights on appeal.

## ***CONCLUSION***

The Board finds that this case is not in posture for decision on whether appellant sustained a shoulder or neck condition as a result of identified employment activities.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the April 8, 2010 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for action consistent with the terms of this decision.

Issued: April 11, 2011
Washington, DC

Richard J. Daschbach, Chief Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board