United States Department of Labor
Employees' Compensation Appeals Board

A.P., Appellant	)	
and	)	**Docket No. 11-1619**
	)	**Issued: February 27, 2012**
U.S. POSTAL SERVICE, POST OFFICE, Philadelphia, PA, Employer	)	

Appearances:
Thomas R. Uliase, 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
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On July 5, 2011 appellant, through her attorney, filed a timely appeal from a March 29, 2011 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant sustained right hand, right wrist, right arm or neck condition in the performance of duty.

FACTUAL HISTORY

Appellant, a 50-year-old window clerk, filed a Form CA-2 claim for benefits on March 1, 2009, alleging that she developed right hand, right arm and neck conditions causally related to

[1] 5 U.S.C. § 8101 *et seq.*

employment factors. She first became aware that these conditions were work related on January 1, 2005.

On March 16, 2009 OWCP advised appellant that it required additional factual and medical evidence to determine whether she was eligible for compensation benefits. It asked her to submit a comprehensive report from a treating physician describing her symptoms and the medical reasons for her condition, an opinion as to whether her claimed conditions were causally related to her federal employment. OWCP requested that appellant submit this evidence within 30 days.

In a March 24, 2009 report, Dr. Jerry Murphy, Board-certified in emergency medicine, stated that he examined appellant on March 23, 2009 for an injury that she allegedly sustained on or about January 1, 2005. Appellant related that, while working as a clerk at the employing establishment, she began to experience a gradual onset of neck, right shoulder, wrist, hand and arm pain. Although she continued to work, she was eventually seen by an orthopedic surgeon and diagnosed with bilateral carpal tunnel syndrome and a right shoulder sprain. Appellant underwent a series of injections in her right shoulder, hand and wrist and was treated with nonsteroidal anti-inflammatory medication. Dr. Murphy treated her for these conditions within the last three to four years and noted that they had become progressively worse.

On examination Dr. Murphy stated that appellant had complaints of persistent and progressive neck, right shoulder, right arm and hand pain, with numbness and tingling in the entire upper extremity. He diagnosed chronic post-traumatic spinal sprain with spasm of the right paravertebral muscles of the cervical and thoracic spine; chronic right shoulder sprain with internal derangement and right cervical neuropathy. Dr. Murphy ruled out bilateral carpal tunnel syndrome by history or acute right carpal tunnel syndrome. He advised that appellant's prognosis for a full and complete recovery, given her continued symptomatology, was guarded. Appellant required a course of job modification including ergonomic conditioning, diagnostic testing, specifically x-rays and magnetic resonance imaging (MRI) scan of the cervical spine and right shoulder, in addition to orthopedic, neurologic and hand surgical evaluations. Dr. Murphy opined to a reasonable degree of medical certainty that her diagnoses and prognosis were directly related to the job-related injuries she sustained on or about January 1, 2005.

In a November 15, 2005 report, received by OWCP on April 17, 2009, Dr. Tanya Stephenson, a specialist in neurology, stated that appellant had been experiencing constant pain in the right upper extremity for approximately one year that worsened with activity. Appellant experienced a cramp-like sensation in her right upper arm which radiated into her right forearm, with swelling. She also had paresthesias in all five fingers. Dr. Stephenson administered an electromyelogram (EMG) which showed carpal tunnel syndrome, with a right median entrapment neuropathy. She stated that there was no evidence of acute denervation or right cervical radiculopathy.[2]

[2] Appellant also submitted reports from physical therapists.

By decision dated June 3, 2009, OWCP denied the claim, finding that appellant failed to submit sufficient medical evidence to establish that her claimed right hand, right arm or neck conditions were related to the factors of her federal employment.

In a June 24, 2009 report, Dr. Murphy indicated that there was a causal relationship between appellant's complaints of persistent bilateral wrist and hand pain with a history of bilateral carpal tunnel syndrome, in addition to acute right carpal tunnel syndrome, right shoulder right neck pain to her regular job activities. He stated that appellant had been working at the employing establishment for the last 24 years, constantly lifting, doing overhead maneuvers, pushing, pulling, carrying and, most importantly, constant repetitive activities; leading to repetitive stress syndrome. Dr. Murphy advised that her diagnoses remained the same. He reiterated, to a reasonable degree of medical certainty, that the diagnoses in his March 24, 2009 report were related to appellant's job duties and contributed to the gradual progression of these ailments since 2005.

On July 7, 2009 appellant requested a review of the written record.

Appellant underwent an MRI scan on April 6, 2009, which showed multilevel degenerative changes, with mild discogenic endplate degenerative signal change from C3-4 through C6-7 and associated moderate disc height loss and moderate anterior spondylotic spurring. The MRI scan revealed: moderate left foraminal stenosis due to facet and uncovertebral hypertrophy at C3-4; moderate central disc osteophyte complex causing mild canal stenosis and moderate-to-severe foraminal stenosis due to facet and uncovertebral hypertrophy at C4-5; central disc osteophyte complex causing mild canal stenosis and moderate to severe foraminal stenosis due to facet and uncovertebral hypertrophy at C5-6; central and left paracentral disc osteophyte complex causing mild canal stenosis and moderate-to-severe left foraminal stenosis due to uncovertebral hypertrophy at C6-7 and mild-to-moderate bilateral foraminal stenosis due to uncovertebral hypertrophy at C7-T1.

In response to OWCP's March 16, 2009 questionnaire, appellant submitted an April 8, 2009 statement received by OWCP on July 8, 2009. She stated that her regular duties as a window clerk entailed lifting for four to eight hours, reaching for four to eight hours, keying for six to eight hours, casing letters for four to eight hours and throwing parcels weighing 5 to 70 pounds for four to eight hours. Appellant indicated that she engaged in reaching above the shoulder for eight hours a day. She advised that she waited four years to report her work-related injuries because the pain was tolerable and did not interfere with her work.

By decision dated September 15, 2009, OWCP's hearing representative set aside the June 3, 2009 decision. He found that the medical evidence was sufficient to require further development.

OWCP referred appellant to Dr. Noubar A. Didizian, Board-certified in orthopedic surgery, for a second opinion examination. In a report dated November 4, 2009, Dr. Didizian advised that appellant had occasional crepitation in the right shoulder, dorsal soreness in the right wrist and occasional numbness of the right hand. He stated that she performed a variety of tasks at work, which involved pushing, pulling, lifting, bending, squatting, reaching and keying. Dr. Didizian asserted that, if appellant were to develop symptoms on the basis of cumulative

trauma, she would have developed her condition within one year from the start of the job rather than years later. The fact that appellant did variable jobs did not classify her under the repetitive cumulative trauma criteria.

On examination, Dr. Didizian stated that appellant had good mobility in the cervical spine with no evidence of any cervical involvement, as confirmed by EMG. He opined that her MRI scan findings involving the anterior fibers of the supraspinatus were not of a traumatic nature, but degenerative. Appellant's symptoms of the right shoulder were not related to her employment. Dr. Didizian noted no pathology today of the right elbow, good mobility with no synovitis in the right wrist; the tests she underwent for carpal tunnel were negative. He concluded, with a reasonable degree of medical certainty, that the nature of her job had no bearing on her current complaints or findings.

By decision dated December 9, 2009, OWCP denied modification of the June 3, 2009 decision.

By letter dated August 25, 2010, appellant, through his attorney, requested reconsideration of the December 9, 2009 decision. Counsel contended that there was a conflict in the medical opinion between Dr. Murphy and Dr. Didizian which required referral to an impartial medical examiner.

By decision dated November 2, 2010, OWCP denied modification.

In a report dated October 18, 2010, received by OWCP on November 4, 2010, Dr. Murphy expressed his disagreement with the opinion of Dr. Didizian. He noted that Dr. Didizian found that appellant did not have carpal tunnel syndrome. While appellant did have right shoulder pathology, it was not related to her job activities. Dr. Murphy stated that she had begun to complain of right upper extremity pain in her shoulder with diminished range of motion, numbness and tingling in the entire right upper extremity, in addition to pain, numbness and tingling in her right hand. These symptoms were all consistent with the results of her MRI scan and EMG. Dr. Murphy disagreed with Dr. Didizian's opinion that appellant did not have carpal tunnel syndrome or right shoulder internal derangement, which were well established based on her medical history and physical examination.

By letter dated January 18, 2011, counsel requested reconsideration.

In a February 11, 2011 report, Dr. Bruce H. Grossinger, Board-certified in psychiatry and neurology, examined appellant and concluded that she had an abnormal study indicating moderate chronic bilateral carpal tunnel syndrome with denervation. Appellant was also borderline distal right median motor latencies as well as prolongation of bilateral median distal sensory latencies at the wrists and palms in addition to moderate denervation of both abductor pollicis brevis muscles. Dr. Grossinger opined that her cumulative work or the employing establishment gave rise to her carpal tunnel syndrome, tenosynovitis and aggravating osteoarthritis of both shoulders, with impingement syndrome and rotator cuff derangement of the supraspinatus and subscapularis muscles. He stated that a motor nerve analysis showed borderline right distal motor latencies with otherwise normal motor parameters; a sensory nerve analysis indicated prolongation of distal median palmar and wrist latencies and an EMG showed

evidence of moderate denervation in both abductor pollicis brevis muscles. This constituted an abnormal study which confirmed moderate bilateral carpal tunnel syndrome with denervation. Based on these findings, Dr. Grossinger advised that appellant's ability to continue working for the employing establishment was limited and that she might be totally and permanently disabled.

By decision dated March 29, 2011, OWCP denied modification.

LEGAL PRECEDENT

An employee seeking benefits under FECA[3] has the burden of establishing that the essential elements of his or her claim including the fact that the individual is an "employee of the United States" within the meaning of FECA, that the claim was timely filed within the applicable time limitation period of FECA, 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 is usually rationalized medical 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]

Section 8123(a) of FECA provides that if there is disagreement between the physician doing the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[7]

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[3] 5 U.S.C. §§ 8101-8193.

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

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

[6] *Id.*

[7] 5 U.S.C. § 8123(a). *See Richard R. Lemay,* 56 ECAB 341 (2005).

ANALYSIS

The Board finds that the case is not in posture for decision as a conflict exists in the medical opinion evidence between Dr. Murphy, a treating physician and Dr. Didizian, a second opinion physician, regarding whether appellant had sustained right hand, right arm, right wrist or cervical condition in the performance of duty. Dr. Murphy diagnosed right-sided carpal tunnel syndrome, cervical pathology and right shoulder internal derangement, as reflected by her MRI scan and EMG. He stated that these were well-established diagnoses based on her medical history and physical examination. Dr. Murphy disagreed with Dr. Didizian's opinion that appellant's cervical pathology, carpal tunnel syndrome and right shoulder were degenerative in nature ad not causally related to her employment as a clerk.

The Board will set aside the May 29, 2011 OWCP decision and remand the case for referral of appellant to an appropriate impartial medical specialist. After such further development of the record as it deems necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that the case is not in posture for decision based on a conflict in medical opinion.

ORDER

IT IS HEREBY ORDERED THAT the March 29, 2011 decision of the Office of Workers' Compensation Programs be set aside and the case is remanded to OWCP for further actions consistent with this decision of the Board.

Issued: February 27, 2012
Washington, DC

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

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board