U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of MAURICE G. SMITH, JR. and DEPARTMENT OF THE NAVY, LONG BEACH NAVAL SHIPYARD, Long Beach, CA

Docket No. 98-987; Submitted on the Record;
Issued August 7, 2000

DECISION and ORDER

Before WILLIE T.C. THOMAS, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issues are: (1) whether appellant has met his burden of proof to establish that he sustained a recurrence of disability on or around June 30, 1997 causally related to his accepted right lateral epicondylitis; (2) whether appellant's accepted temporary aggravation of right ulnar neuropathy ceased as of December 31, 1995 and (3) whether the Office of Workers' Compensation Programs properly denied appellant's request for surgical correction of the accepted ulnar neuropathy on January 7, 1998.

In this case, appellant has filed two separate claims, both involving injuries to his right elbow. On May 2, 1988 appellant, then a 41-year-old pipefitter, filed a claim alleging that he developed a right elbow condition as a result of repeated hammering in the course of his federal employment duties. He missed intermittent days from work between February 17 and May 2, 1988 when he was placed on light duty. Appellant continued to work a series of light-duty positions.

On December 12, 1988 the Office accepted appellant's claim for right lateral epicondylitis. On April 26, 1990 the Office authorized surgical repair of appellant's elbow condition, as requested by appellant's physician, Dr. Jay Jazayeri, a Board-certified orthopedic surgeon, which was performed on May 3, 1990.

Following the surgery, on August 6, 1990, Dr. Jazayeri released appellant to light duty, with restrictions on twisting, bending or lifting over 20 pounds with the right arm. He released appellant from his care on April 8, 1991. In a narrative medical report dated July 15, 1991, Dr. Jazayeri stated that appellant's condition was permanent and stationary and rated his degree of permanent impairment. He stated that appellant was restricted from pushing, pulling, twisting or carrying objects heavier than 25 pounds and might occasionally require physical therapy or medication.

By decision dated November 5, 1992, the Office granted appellant a schedule award for a 22 percent permanent impairment of his right upper extremity.

On July 26, 1994 appellant filed a claim alleging that he sustained a recurrence of disability on July 7, 1994, causally related to his accepted epicondylitis. He stopped work that date and returned to work on July 10, 1994. As the medical evidence appellant submitted in support of his claim seemed to indicate that appellant had actually sustained a second medical condition, unrelated to the prior accepted epicondylitis, by letter dated August 9, 1994, the Office advised appellant to file a separate claim for this condition. The Office also informed appellant that, should he wish to pursue his claim for a recurrence of epicondylitis, the medical reports of record were insufficient to establish the claim and advised him to submit additional medical evidence.

On November 30, 1994 appellant, at that time no longer working on ships but performing the duties of a dispatcher, materials expediter and deliveryman, filed a claim for occupational disease, OWCP No. A13-1062054, alleging that he developed right ulnar nerve compression as a result of his employment duties. He continued to separately pursue his July 26, 1994 claim for recurrence of disabling epicondylitis.

In a decision dated July 24, 1995, the Office denied appellant's claim for a recurrence of disability on the grounds that he had not submitted any medical evidence to support that he sustained a recurrence of disability causally related to his accepted right elbow epicondylitis. The Office continued to develop appellant's November 30, 1994 occupational disease claim for ulnar nerve compression.

On January 28, 1997 after a period of medical and factual development, the Office accepted appellant's November 30, 1994 claim for temporary aggravation of right ulnar neuropathy, ending December 31, 1995.

On September 23, 1997 appellant filed a claim (Form CA-2a) alleging that he sustained a recurrence of disability on June 30, 1997, causally related to his accepted right elbow epicondylitis. He did not stop work, however, until September 10, 1997. Appellant stated that he had suffered pain in his right elbow ever since the original injury, ranging from severe pain before his 1990 surgery, to mild pain after the procedure. He alleged that from 1990 to 1996 he had worked outside of his light-duty restrictions and as a result, his elbow condition had worsened.

By decision dated January 7, 1998, the Office found the evidence of record insufficient to establish that appellant sustained a recurrence of disability on or about June 30, 1997 causally related to the 1988 accepted employment-related epicondylitis.

In a separate decision also dated January 7, 1998, the Office declined to authorize right elbow surgery for repair of his right ulnar nerve compression, as the Office previously found that the condition had ended on December 31, 1995.

The Board initially finds that appellant has failed to meet his burden of proof to establish that he sustained a recurrence of disability on or about June 30, 1997, causally related to his accepted right lateral epicondylitis.

When an employee, who is disabled from the job he held when injured on account of employment-related residuals, returns to a light-duty position or medical evidence of record establishes that he can perform the work of a light-duty position, the employee has the burden of establishing by the weight of the reliable, probative and substantial evidence a recurrence of total disability and show that he cannot perform such light duty. As part of the burden, the employee must show a change in the nature and extent of the injury-related condition or a change in the nature and extent of the light-duty job requirements.[1]

Appellant has not submitted sufficient medical evidence to establish that he sustained a change in his physical condition when he filed his claim for recurrence of disability causally related to his accepted right epicondylitis. With respect to his right epicondylitis condition, appellant submitted contemporaneous medical reports by his treating physician, Dr. Jazayeri, a Board-certified orthopedic surgeon. In a report dated June 3, 1997, prior to appellant's work stoppage, he, who has treated appellant since January 1990, provided a detailed update of appellant's orthopedic condition. Dr. Jazayeri stated that appellant was initially diagnosed with right epicondylitis or tennis elbow, which was subsequently surgically corrected. He noted appellant later developed numbness of the right upper extremity related to the ulnar nerve, but that the Office did not authorize surgery for this condition. In addition, Dr. Jazayeri noted that during the course of his office visits, appellant developed neck pain with radiation to the right upper extremity, and that x-rays revealed degenerative arthritic changes at C5-6, of mild to moderate to degree. He noted that these degenerative changes have been responsible for some of the neurological findings of appellant's right upper extremity. Dr. Jazayeri stated that at the time of his current examination, appellant's diagnoses included cervical spine degenerative arthritis, status post right tennis elbow, repaired and ulnar neuropathy of the right elbow. He explained that both of the right elbow conditions were the result of repetitive overuse of the right upper extremity. Dr. Jazayeri went on to say:

> "The patient's condition is not expected to result in full recovery. His elbow condition is now stabilized as far as the tennis elbow is concerned. The condition of the ulnar nerve entrapment is less clear and is still present. It has not stabilized as yet. Should the patient have surgery, three to six months after surgery, the condition will be expected to be stabilized.
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> "Since the patient is a laborer using the right upper extremity repetitively for different activities, the medical condition of the patient, specifically, tennis elbow, ulnar nerve entrapment and cervical spine degenerative arthritis, could adversely affect the patient's ability to perform on the job. Off the job, the patient is also likely to have to limit his activities due to limitations imposed upon him because of the right upper extremity.

[1] *Jackie B. Wilson*, 39 ECAB 915 (1988); *Terry R. Hedman*, 38 ECAB 22 (1986).

"The tennis elbow is expected to be stable. The ulnar neuropathy is likely to progress, especially with repetitive use of the upper extremity. The degenerative arthritic changes of the cervical spine are unpredictable. They could stay the way they are for a long time or they may start to deteriorate.

"The patient is not likely to develop sudden incapacitation associated with the medical condition. However, gradual progression of the ulnar nerve entrapment, as well as degenerative arthritic changes, could be disabling for the patient. If the patient is not restricted in terms of use of the right upper extremity, he might be in danger in terms of using machinery or equipment which may require full control of the right upper extremity. The fact that the patient has weakness subsequent to his tennis elbow, as well as numbness and compromised sensation in his right upper extremity because of entrapment of the ulnar nerve, could be the medical basis for endangerment due to the right upper extremity.

"It should be mentioned that most recently, the patient has been having progressive problems with the neck, in terms of degenerative arthritis and cervical spine stain. The patient has had to use more and more pain medications to control the pain, and he has been more limited because of this condition.

"Because of the above conditions, it is recommended that the patient have limited use of his right upper extremity. The patient should be restricted in lifting of objects weighing more than 10 pounds and repetitive use of the upper extremity, as well as avoidance of conditions which would require precise sensory determination by use of the upper extremity. These restrictions would have to be followed, otherwise, the risk involved would be detrimental for the patient."

On June 18, 1997 Dr. Jazayeri completed a form report in which he indicated, without further elaboration or explanation, that appellant was under his care and would remain totally disabled until his next appointment on June 25, 1997. At the time of this report, however, appellant was still working and continued to work until September 10, 1997.

In his report dated June 30, 1997, the same date appellant alleges his recurrence began, Dr. Jazayeri stated that appellant was complaining of continued pain in his right elbow on an on and off basis, although he reported that his neck condition was improved. Physical examination revealed mild tenderness over the lateral epicondyle area of the right elbow and range of motion was satisfactory. Dr. Jazayeri further stated:

"I would like to clarify my statement about the patient's elbow in my report of June 3, 1997. On page three of the report, first paragraph, where it states that the tennis elbow is expected to be stable, it means that the patient's condition will not substantially change from its present condition. The present condition is that of recurring tennis elbow, in that the elbow is weaker than normal, and the patient is expected to have periods of pain and discomfort, along with decreased strength."

Dr. Jazayeri added that he would see appellant again in four weeks and did not comment on appellant's ability to work.

In a follow-up report dated July 28, 1997, Dr. Jazayeri reported that appellant continued to complain of neck and right elbow pain, and that physical examination revealed a satisfactory range of motion and mild tenderness over the neck area. He prescribed medication and stated that he would see appellant again in four weeks. Dr. Jazayeri did not comment on appellant's ability to work. In his next report of record dated September 10, 1997, he stated that appellant continued to have pain in his right elbow and neck, and that physical examination revealed tenderness over the right epicondyle area and over the right cervical spine. Dr. Jazayeri prescribed medication and concluded that appellant was advised to stay off work for the next four weeks so that he could recover from the recurrence of his injuries.

In a letter dated September 26, 1997, the Office advised appellant that if he considered his cervical condition was related to his work activities, he should file a separate claim for that condition. There is no evidence in this record that appellant has filed such a claim.

In a report dated October 22, 1997, Dr. Jazayeri noted that appellant now complained of right wrist and thumb pain. Physical examination revealed tenderness of the first CMC joint, pain with abduction and extension of the thumb and satisfactory range of motion. He diagnosed de Quervain's disease of the right thumb with degenerative arthritis of the CMC joint and added that this was a continuation of the overuse syndrome. Dr. Jazayeri prescribed medication and stated he would see appellant again in four weeks. In a follow-up report dated November 19, 1997, the last report submitted before the Office's January 7, 1998 decision, he noted that appellant reported that his thumb and neck conditions were feeling better and that his elbow condition was about the same. Physical examination revealed minimal tenderness over the neck, elbow and thumb, and that the thumb exhibited full range of motion. Dr. Jazayeri further noted that appellant informed him that because of his limitations, he had been placed on total disability.

Although Dr. Jazayeri stated in his September 10, 1997 report that he had advised appellant to stay off work due to a recurrence of his condition, the physician did not describe any significant change in appellant's condition which would account for his inability to perform his light-duty job or provide any objective physical findings in support of his conclusion. In addition, while appellant stated that his recurrence of disability began on June 30, 1997, appellant in fact worked until September 10, 1997, approximately three months later.

In addition, the evidence of record does not establish a material change in appellant's light-duty job requirements. On appellant's claim for recurrence of disability, the employing establishment indicated that since June 23, 1993, appellant had been performing the job duties of a deliveryman, expediter and dispatcher. A description of the physical demands of the position indicated that appellant would not be required to lift more than 20 pounds and would otherwise be within the restrictions set by Dr. Jazayeri. While the Office subsequently accepted that from 1990 to 1996, appellant in fact worked outside of his physical restrictions, lifting in excess of 25 pounds on numerous occasions, as well as pushing, pulling and performing repetitive twisting, in his testimony given on May 1, 1996, appellant stated that he had not been performing outside of his physical restrictions for approximately a year. Therefore, at the time of his alleged recurrence of disability on June 30, 1997, appellant had not been performing outside of his physical restrictions for more than two years and there is no evidence that there

was a change in his light-duty position which caused his recurrence of disability.[2] Consequently, as appellant has not established a material change in his light-duty job, he has not met his burden of proof.

The Board further finds that with respect to the issues of whether the Office properly determined that appellant's accepted temporary aggravation of right ulnar neuropathy ceased as of December 31, 1995, and whether the Office properly denied appellant's request for corrective surgery of his accepted ulnar neuropathy, this case is not in posture for a decision and requires additional medical development.

The fact that the Office accepts appellant's claim for a specified period of disability does not shift the burden of proof to appellant to show that he or she is still disabled. The burden is on the Office to modify payment of compensation benefits. The Office's burden includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[3]

With respect to appellant's accepted ulnar neuropathy, the record contains additional medical reports from Dr. Jazayeri which specifically pertain to appellant's ulnar neuropathy condition. In his reports dated February 8 and August 3, 1994, Dr. Jazayeri stated that appellant had been diagnosed, through nerve conduction studies, with ulnar nerve compression at the right elbow. He emphasized that this was a new injury and was the result of his work-related activities and was not part of the old February 17, 1988 injury. Dr. Jazayeri concluded that appellant required surgery for anterior transposition of the ulnar nerve at the right elbow. In reports dated April 19, August 9, September 11 and October 27, 1995 and September 27, 1996, he stated that appellant's condition remained unchanged and that he still required surgical correction of his ulnar nerve compression. In his report dated February 21, 1997, Dr. Jazayeri noted that x-rays of appellant's cervical spine revealed degenerative arthritis at C5-6 and diagnosed right radiculopathy, with possible ulnar neuropathy, and in a follow-up report dated April 7, 1997, Dr. Jazayeri noted that appellant was doing well and was advised to continue with his therapy and medication regimen. In his June 3, 1997 report updating appellant's orthopedic condition, he stated that while appellant's condition was stable with respect to his epicondylitis, the condition of the ulnar nerve entrapment was less clear and still present, having not yet stabilized. Dr. Jazayeri added that should the patient have surgery, three to six months after

[2] In addition, there is evidence in the record that appellant received a notice of a reduction-in-force (RIF) dated September 25, 1997, which indicated that his position would be terminated effective September 30, 1997. As appellant stopped work prior to the effective date of the RIF, it is therefore unclear whether the two events are connected. In the event that appellant did stop work because of the pending RIF, the Board notes that, in a decision dated August 1, 1994, the Office determined that appellant had been reemployed as a modified pipefitter effective June 27, 1993 and that this position fairly and reasonably represented his wage-earning capacity. The Office concluded that as his actual wages met or exceeded the wages of the job held when injured, he had no loss of wages. Although the Office will review a case in a different manner if there has been a withdrawal of the light-duty position, in cases in which the withdrawal of the position is due to a RIF, the status of the claimant with an established wage-earning capacity does not change. Thus, a claim for recurrence of disability in such a situation must be denied unless the claimant shows a material change in his medical condition. Federal (FECA) Procedure Manual, Part 2 -- Claims, *Recurrences*, Chapter 2.1500.7(a)(4) and 2.1500.9(a) (January 1995).

[3] *Raymond W. Behrens*, 50 ECAB ___ (Docket No. 97-1289, issued January 14, 1999).

surgery, the condition will be expected to be stabilized. He added that appellant's ulnar neuropathy was likely to progress, especially with repetitive use of the upper extremity.

On August 28, 1996 the Office referred appellant, together with a statement of accepted facts and a list of questions to be answered, to Dr. Michael M. Mahdad, a Board-certified neurologist, for a second opinion examination.[4] In the statement of accepted facts, the Office confirmed that it was accepted that appellant lifted in excess of 25 pounds on numerous occasions and also pushed, pulled and performed repetitive twisting while making deliveries at the shipyard. These duties, which were outside of his physical restrictions, were performed from 1990 through 1995.

In a report dated October 4, 1996, Dr. Mahdad reviewed the relevant medical evidence of record as well as appellant's medical and employment histories. After performing a complete physical examination, he diagnosed right ulnar neuropathy at the elbow, mild and history of previous right tennis elbow surgery.[5] Dr. Mahdad further discussed appellant's condition, stating:

> "Although this patient has some signs and symptoms of right ulnar neuropathy, this appears to be mild, at least clinically. It is my opinion that surgery on the ulnar nerve will not cure this patient's problem and, considering his age, it may add to the problem and might even worsen his condition.
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> "Since the patient's previous nerve conduction study was in 1994 and the results were somewhat confusing, since he showed bilateral problems although the patient complains of only right-sided numbness and pain, I suggest he undergo another EMG [electromyogram]/nerve conduction study of the right arm, to rule out other possibilities, including a carpal tunnel syndrome or cervical neuropathy causing his current problems.
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> "The patient's current symptoms are related to his job, including repetitive movements of the elbow and lifting. Although this patient had a limitation of lifting not more than 20 pounds, it was noted in statement of facts, that he was lifting, on numerous occasions, more than 25 pounds, which may aggravate his right elbow complaints. This condition is permanent, however, strict adherence to his job limitations would prevent further worsening of his condition…."

[4] Initially, in a decision dated July 24, 1995, the Office denied appellant's claim for right ulnar neuropathy. Appellant requested an oral hearing, which was held on May 1, 1996. At the hearing, appellant presented oral testimony, as well as written witness statements, which the Office hearing representative found established that he had worked outside of his physical restrictions from 1990 to 1996. In a decision dated August 9, 1996, the Office hearing representative remanded the case to the Office and instructed them to refer appellant to a second opinion physician, together with an amended statement of accepted facts.

[5] Dr. Mahdad initially listed his diagnosis as left ulnar neuropathy, mild, but later corrected this error to reflect right ulnar neuropathy, mild.

Following the additional nerve testing, Dr. Mahdad submitted a follow-up report in which he offered his conclusions after reviewing the results of the studies. Dr. Mahdad stated, in pertinent part:

> "Considering my original consultation report, on October 4, 1996 and the result of the patient's current studies, I do not find any reason for this patient to have an ulnar nerve decompression done. There is no evidence of any ulnar neuropathy of an electrical basis. The patient has a mild degree of cervical radiculopathy at the C6 level which would account for this right arm pain, feeling of weakness of the right arm, and also occasional numbness of the hand. His pain in the elbow with repetitive bending and heavy lifting is due to his soft tissue injury and previous tennis elbow surgery rather than any type of ulnar neuropathy.
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> "The work restrictions, including no repetitive bending of the right elbow, are still in force to prevent an increase of his right elbow symptoms. Further investigation of his cervical radiculopathy should be best addressed by his treating physician, Dr. Jazayeri."

By letter dated November 19, 1996, the Office asked Dr. Mahdad to explain, with medical reasoning, whether appellant's aggravation of ulnar neuropathy was permanent or temporary.

In a response dated December 18, 1996, Dr. Mahdad stated:

> "I performed an EEG [electroencephalogram] and nerve conduction study on November 1, 1996, which I believe to be self-explanatory. Surgery was not indicated as there was no evidence for any ulnar neuropathy of an electrical basis. It was found that he had a mild degree of cervical radiculopathy at the C6 level which would, as I explained, be the cause for the right arm pain, feeling of weakness of the right arm and the occasional numbness in the hand. The elbow pain was due to the soft tissue injury and the previous tennis elbow surgery rather than any type of ulnar neuropathy.
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> "The patient's condition is permanent in the sense that it will not be resolved by surgical intervention. The level of his disability will likely not worsen if he adheres to the restrictions as outlined in my prior report. He can expect to experience periods of exacerbation (increase in level of pain or function) if he performs duties outside the restrictions indicated."

By letter dated January 15, 1997, the Office again requested clarification from Dr. Mahdad with respect to his exact diagnosis, whether or not any medical condition appellant has is related to factors of employment listed in the statement of accepted facts, and whether there is a period of temporary or permanent aggravation.

In his final report of record, dated January 16, 1997, Dr. Mahdad responded to the Office's questions, stating, in pertinent part:

> "Initially, when the patient was seen, it appeared that the patient might have ulnar neuropathy or residuals of his preexisting condition, epicondylitis. On October 4, 1996 I requested that the patient undergo EMG/nerve velocity conduction studies in order to resolve the question of whether there were documentable new findings. EMG/nerve velocity conduction studies resolved the issue. There is no evidence of disabling ulnar neuropathy, no new injury or need of operation to the elbow as a result of ulnar neuropathy.
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> "By your letter, you acknowledge that the patient worked outside his light-duty restrictions. I, by my report to you of October 4, 1996 relayed that, yes, the patient did have findings as a result of his working outside his work restrictions, *however, because of his preexisting condition which a settlement was offered, work restrictions were enacted, he could be expected to experience flare ups IF HE WERE TO CONTINUE TO WORK OUTSIDE HIS RESTRICTIONS not that he had a new finding.*
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> "In this sense, his condition is permanent. It will never resolve. If he performs activities that will irritate his elbow *he can be expected to have longer and longer periods of disability.*
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> "Conversely, if he does not perform activities outside of his work restriction, *he will not experience any exacerbations.* If you continue to use an eraser it will wear away, if you do n[o]t it will remain the same.
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> "With regard to permanent aggravation. There has not been any new injury. He has exacerbation of a preexisting condition. This exacerbation will resolve, flare, resolve. It will not go away unless *he does not perform activities that will exacerbate his condition.* In this sense his condition is permanent. Surgery will not resolve his condition, in fact it may add to his level of complaints.
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> "The C6 radiculopathy is an incidental finding. Addressing the right elbow injury only, he obviously has permanent restrictions and a condition that will only worsen, never resolve, and is permanent in nature.
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> "My final diagnosis is simply stated. He does have mild ulnar neuropathy and an incidental finding of C6 radiculopathy. He complaints are a direct result of the epicondylitis and subsequent surgery and working outside his restrictions.
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> "I would further state that there has been a period of temporary exacerbation (aggravation) which occurred during the time he worked outside his restrictions and resolved once he was no longer required to perform these strenuous duties." (Emphasis in the original.)

The Federal Employees' Compensation Act, at 5 U.S.C. § 8123(a), in pertinent part, provides: "If there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination."[6]

In the present case, appellant has alleged that he continues to suffer from right ulnar neuropathy, causally related to his employment, and that this condition requires surgical correction. As part of appellant's burden of proof, he must submit rationalized medical evidence based upon a complete and accurate factual and medical background, showing a causal relationship between the injury claimed and his accepted condition.[7] To support his claim, appellant submitted numerous narrative reports from Dr. Jazayeri, his treating physician, who diagnosed ulnar neuropathy causally related to appellant's work activities, and opined that appellant requires a surgical anterior transposition of the ulnar nerve in order to correct this condition. However, Dr. Mahdad, the Office second opinion physician, is in disagreement with appellant's physician as to the duration of appellant's ulnar neuropathy, stating that appellant's condition resolved when appellant ceased working outside of his physical restrictions. He further disagreed with Dr. Jazayeri as to the necessity for surgical correction of appellant's ulnar neuropathy. Consequently, the case will be remanded. On remand, the Office should combine the case records for OWCP No. A13-856052 and OWCP No. A13-1062054, and then refer appellant, together with a comprehensive statement of accepted facts, questions to be answered and the complete, combined case record, to an appropriate Board-certified specialist for an impartial medical examination and a rationalized medical opinion to resolve the medical conflicts remaining in this case.[8]

[6] 5 U.S.C. § 8123(a); *Esther Velasquez*, 45 ECAB 249, 252-53 (1993).

[7] *Kathryn Haggerty*, 45 ECAB 383, 389 (1994); *Steven R. Piper*, 39 ECAB 312 (1987).

[8] *Kathryn Haggerty*, *supra* note 8; *Carol A. Dixon*, 43 ECAB 1065, 1071 (1992).

Therefore, the January 7, 1998 decision of the Office of Workers' Compensation Programs denying appellant's September 23, 1997 claim for a recurrence of disability is affirmed. The Office's January 7, 1998 decision denying appellant's request for surgery for his accepted ulnar neuropathy, and January 28, 1997 decision finding that appellant's aggravation of ulnar neuropathy ceased as of December 31, 1995, are hereby set aside and the case is remanded for further action in accordance with this decision and order of the Board.

Dated, Washington, D.C.
August 7, 2000

Willie T.C. Thomas
Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member