



involving her shoulders, hands and arms. The patient states she reaggravated her injury after casing mail through overhead reaching and lifting packages.” Dr. Butler examined appellant and diagnosed bilateral rotator cuff strain, bilateral wrist strain and cervical strain. He indicated with a mark that his findings and diagnoses were consistent with appellant’s account of injury or onset of illness. Dr. Butler stated: “Condition is work related.”

On July 1, 2004 the Office accepted appellant’s claim for bilateral wrist and rotator cuff strains and cervical strain.<sup>1</sup>

On December 2, 2004 appellant filed a separate claim for injury to her lower back vertebrae and nerve damage: “As a letter carrier I do a lot of lifting, twisting, bending, pushing, pulling, braking the vehicle.” On February 9, 2005 the Office accepted this claim for lumbar sprain/strain, displacement of lumbar intervertebral disc without myelopathy, and thoracic or lumbar intervertebral disc degeneration.<sup>2</sup>

Because the two case files involved similar injuries, the Office “doubled” or consolidated them in March 2006, with OWCP File No. 13-2101703 serving as the master file.

On April 27, 2004 Dr. Alvin M. Yee, a specialist in anti-aging and regenerative medicine, also a specialist in occupational and sports medicine, saw appellant to evaluate occupational injuries to her neck, shoulders, arms, wrists, back, hips and legs reported on March 25, 2004. He described appellant’s duties as a letter carrier in some detail. Dr. Yee noted that appellant began to notice pain in the subject body parts progressively while engaged in her various duties. He noted appellant’s head-on collision in a postal vehicle in 1986 and her subsequent and current complaints. Dr. Yee described his findings on physical examination and review diagnostic studies. He diagnosed: (1) cervical disc displacement; (2) cervical radiculopathy; (3) right rotator cuff tear (distal supraspinatus); (4) bilateral shoulder impingement syndrome; (5) bilateral carpal tunnel syndrome; (6) bilateral medial epicondylitis; (7) thoracic sprain/strain; (8) right knee sprain/strain; (9) lumbar disc displacement; and (10) lumbar radiculopathy. Dr. Yee offered the following opinion on causation:

“It does appear based on the information available to me at this time and the information provided by the patient that her conditions are caused by, due to, and arising out of the work activities for the [employing establishment] while working as a letter carrier.

**“Neck and Upper Back:**

“With regards to the neck and upper back, in 1986 while delivering mail on her route, the patient was involved in a head on collision in her postal vehicle resulting in whiplash to her neck. The patient did not receive any therapy and was

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<sup>1</sup> OWCP File No. 13-2101703.

<sup>2</sup> OWCP File No. 13-2118698. On March 22, 2006 the Office informed appellant’s congressman that the accepted industrial conditions were: cervical disc syndrome, cervical radiculopathy, right rotator cuff sprain, bilateral shoulder impingement, bilateral carpal tunnel syndrome, bilateral medial epicondylitis, thoracic spine sprain, right knee sprain, displacement of the lumbar disc and lumbosacral radiculitis.

returned to her regular duties after two weeks. She states that the neck pain never resolved completely. After a trauma such as this, the patient's continuing complaints can be attributed to resultant edema, petechial-type hemorrhage, and the formation of adhesions with eventual scar tissue causing chronic nerve root irritation. In addition, [she] has been working as a letter carrier for the last 19 years, which requires the patient to perform approximately three to four hours of casing. The patient states that[,] when she is casing the mail, she is required to repetitively turn and move her neck up and down approximately 45 degrees and 90 degrees to read the addresses on the mail while casing. In addition, she states that she is constantly twisting and turning her neck back and forth while she is casing the letters into their appropriate case. This repetitive flexing and extending of the neck has contributed to the disc protrusions at the levels of C3-C4, C4-C5, C5-C6 and C6-C7, which can be seen on MRI [magnetic resonance imaging] [scan]. The repetitive flexing and extending of the neck has stretched and caused microtears in the soft tissue of the cervical spine including the surrounding musculature, ligaments and other soft tissue structures, resulting in edema and inflammation. The inflammation of these structures narrows the space with which the nerves pass through contributing to the numbness and tingling the patient experiences down her arms, to her elbows, wrists, and fingers, bilaterally.

**“Right and Left Shoulders:**

“The right and left shoulder pathologies are caused by a cumulative trauma with repetitive motion with the sorting and casing of letters. When the patient constantly pushes, pulls, and lifts tubs of trays full of mail weighing up to 25 [pounds], it creates an increased biomechanical stress to the tendons of the rotator cuff of the shoulder, making it more susceptible to a tear. In addition, the repetitive pushing and pulling of hampers weighing between 200 and 300 [pounds] combined with the repetitive overhead movements required when casing has resulted in the fibers of the supraspinatus tendon to become inflamed, weakened and torn. This can clearly be seen on MRI [scans] of the right shoulder taken on May 26, 2004.

“In addition, when the patient elevates her right and left shoulder with the decreased joint space of the acromioclavicular joint demonstrated on x-rays, it can further narrow the space where the tendons, ligaments, arteries and nerves pass through. This results in compression and impingement of these structures, therefore causing a sharp pain in the right and left shoulders.

**“Right and Left Wrists and Elbows:**

“The right and left wrist and elbow pathologies are caused by cumulative trauma from repetitive flexing and extending as well as repetitive radial and ulnar deviation, which is required by the patient while working as a letter carrier.

“The patient states that when she works as a letter carrier she is required to sort approximately 1[,]<sup>500</sup> to 3[,]<sup>1000</sup> pieces of mail, which may vary on any given

day. She states as she is preparing to case the letters she lifts trays of letters weighing approximately 15 to 20 pounds, places them on a ledge, and grabs a handful of letters with her left hand which can be approximately 100 pieces and then takes one letter at a time with her right hand holding the letters between her thumb and index finger and then place it into its appropriate case. She also lifts tubs of mail, which can weigh between 25 to 50 pounds. In addition, she also pushes gurney, which can weigh between 300 to 400 pounds. She states that she cases mails for approximately four to six hours and performs these motion five days a week. The casing which she performs requires repetitive movement of the wrist which has caused inflammation and compression on the structures of the carpal tunnel including the median nerve resulting in numbness in the hands and fingers and therefore resulting in carpal tunnel on the right and left wrist.

“In addition, the repetitive extending and flexing of the wrist required when casing mail has irritated the common flexor musculature located on the inner aspect of the elbow. The repetitive movement has caused inflammation resulting in a chronic strain of the tendons and ligaments attaching to the medial epicondyle. Severely sprained ligamentous tissue results in the formation of fibrous scar tissue causing tightness, stiffness, decreased range of motion and pain in the injured area.

**“Lumbar spine:**

“The lumbar pathology was caused by the repetitive bending, reaching, lifting and squatting, which are required when the patient performs her duties as a letter carrier. When the patient lifts the trays and tubs full of mail which can weigh between 15 to 50 pounds, the soft tissue of the lumbar spine including the surrounding musculature, ligament, and other soft tissue structures are stretched and over-stretched resulting in edema and inflammation. The inflammation of these structures causes further narrowing of the space to which the nerves pass through and causes radiating pain in the distribution of the L4, L5 and S1 dermatome, which travels down the anterior lower thigh, top of the foot, outside of the foot, great toe and small toe. This is consistent with nerve conduction velocity and electromyography findings in addition to the patient’s symptomology.

**“Right Knee:**

“With regards to the right knee, the patient has been working as a letter carrier for approximately 19 years, which requires her to case mail. She mentions that when she is casing her mail, she performs repetitive bending when lifting trays or parcels from the floor to her workstation. In addition, the patient explains that when delivering the mail, she would climb approximately 200 steps a day while carrying a shoulder satchel on her right shoulder which weighed between 35 and 45 pounds. These activities over time have caused repetitive high stress and increased loading onto the right knee, which has caused irritation and degeneration of the musculature and tendons, which attach to the patella and tibia.

Consequently, her muscles and ligaments have become weak which has predisposed the patient to premature degeneration and has strained the surrounding musculature of the right knee, which can be seen on the patient's x-rays and the patient's symptomatology."

On October 13, 2004 Dr. Janet Dunlap, a consulting Board-certified orthopedic surgeon and spinal specialist, related appellant's history and complaints. She stated that appellant worked as a letter carrier for 20 years:

"This job entails repetitive bending, twisting, reaching forward with her arms to deliver mail, and heavy lifting. Approximately four years ago, [appellant] began to develop the gradual onset of burning pain in the lower back and medial thighs, with burning in the left anterior thigh. She has developed a numbness and dead sensation in the anterior aspect of the left thigh. The symptoms go to the knees but not distally. Symptoms are aggravated with standing and walking. [Appellant] has a sensation that the right knee is weak and give way, for the last six months. She has also a 6[-] to 12[-]month history of numbness in the right hand including all five digits but the symptoms have improved over the last two months since she has not been doing her mail route. [Appellant] gets aching pain in her neck which radiates into the upper arms and forearms bilaterally. She has a sensation of weakness in the hands with gripping or using them. [Appellant's] main complaint is that of the low back and thigh, right greater than left. She notices increased shoulder pain with reaching, and reports that she has been diagnosed with a 'rotator cuff problem.' [Appellant] reports that she was diagnosed with tendinitis in that area in approximately 1992. She has had five months of physical therapy for her neck and back, as well as treatment with anti-inflammatory medications. Diagnostic studies have included x-rays and MRI scan but unfortunately, these were not available for the appointment today."

Dr. Dunlap reviewed medical records from June to September 2004 and described her findings on physical examination. She diagnosed: (1) multilevel lumbar disc degeneration and stenosis, by report; (2) low back pain with bilateral lumbar radiculitis, without neurologic defect; (3) multilevel cervical disc degeneration with foraminal stenosis; (4) bilateral cervical radiculitis, by report, without neurologic deficit or myelopathy; (5) right carpal tunnel syndrome; (6) left rotator cuff impingement syndrome; (7) acromioclavicular synovitis; and (8) right rotator cuff impingement syndrome with concomitant cuff tear.

Dr. Dunlap reported that appellant had stenosis in both the cervical and lumbar, which adequately explained her radicular-type symptoms in all four extremities. This was superimposed on rotator cuff pathology and right carpal tunnel syndrome. "These degenerative changes are largely age related," she stated. Dr. Dunlap addressed causal relationship: "Patient's symptoms have been aggravated by her work activities on a cumulative traumatic basis, with repetitive bending, twisting, and lifting over 20 years as a [l]etter [c]arrier."

On December 8, 2004, however, Dr. Dunlap reported that appellant had diffuse somatic complaints of uncertain etiology. She noted that appellant's subjective complaints involving the neck and back and extremities circumferentially outweighed the objective findings and "are not

quite classic for stenosis.” On February 9, 2005 Dr. Dunlap narrowed her diagnoses to (1) multilevel lumbar disc degeneration and stenosis, (2) low back pain with bilateral lumbar radiculitis without neurological deficit, (3) multilevel cervical disc degeneration with foraminal stenosis, and (4) bilateral cervical radiculitis, without neurological deficit or myelopathy. She reported that appellant clearly had multilevel preexisting degenerative changes, which caused some of her disability. But Dr. Dunlap also attributed half of appellant’s disability to work exposure alone.

On April 24, 2006 Dr. Ghassan S. Tooma, an orthopedic surgeon specializing in hand and upper extremity surgery, noted the basic physical demands of appellant’s position and her current complaints. He reported his findings on physical examination, reviewed diagnostic studies and diagnosed the following: (1) right shoulder impingement syndrome with supraspinatus tendinopathy and supraspinatus tear; (2) bilateral carpal tunnel syndrome; and (3) C3-4, C4-5 and C6-7 discogenic disease and spondylosis with varying degrees of central and neural foraminal stenosis. Dr. Tooma reported: “Causation is felt to be industrial in nature with regards to her right shoulder and bilateral wrist conditions related to repetitive cumulative trauma to the right shoulder and both wrists and hands.”

Appellant claimed compensation for total disability from July 17 to September 1, 2006. On July 17, 2006 Dr. Tooma related appellant’s complaints and on physical examination noted a positive impingement sign at the right shoulder, no change in range of motion, and pain with rotation of her neck, but not specifically a positive Spurling test. Repeating his diagnoses from April 24, 2006, he placed appellant on temporary total disability “at this time, since with the condition she is in, it is unlikely that she is able to perform duties even with modifications.”

The Office referred appellant, together with medical reports and a statement of accepted facts for the consolidated cases,<sup>3</sup> to Dr. Joseph Pierce Conaty, a Board-certified orthopedic surgeon, for a second opinion evaluation. On December 18, 2006 Dr. Conaty reviewed the statement of accepted facts, the medical records submitted and the history of appellant’s current illness. He reported his findings on physical examination and reviewed x-rays. Dr. Conaty diagnosed: (1) mild bilateral carpal tunnel; (2) strain/sprain, thoracic, recovered; (3) medial epicondylitis, recovered; (4) strain/sprain, right rotator cuff, secondary to ongoing aging degenerative process; (5) displacement of the cervical disc, without myelopathy, ongoing degenerative process; and (6) displacement of the lumbar intervertebral disc, without myelopathy, recovered. He commented:

“The findings in respect to the issue of carpal tunnel demonstrate a minimally positive Phalen’s test. In respect to the cervical degenerative problem, this is noted with the restriction of range of motion and x-ray and MRI [scan] changes of degenerative disc disease. The shoulder tear is noted with objective MRI [scan]

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<sup>3</sup> The statement of accepted facts indicated that the Office accepted appellant’s March 25, 2004 claim for (1) strain/sprain of shoulder and upper arm, rotator cuff, bilateral, (2) strain/sprain of wrist, bilateral, and (3) neck strain/sprain. The statement of accepted facts indicated that the Office accepted appellant’s December 2, 2004 claim for (1) bilateral carpal tunnel syndrome, (2) thoracic back strain/sprain, (3) medial epicondylitis, (4) right shoulder/rotator cuff strain/sprain, (5) displacement of cervical intervertebral disc without myelopathy, and (6) displacement of lumbar intervertebral disc without myelopathy.

changes and limited range of motion. It is my opinion that these are ongoing, aging degenerative problems and not specifically work related.”

Asked whether his diagnosis of appellant’s condition was medically connected to the factors of employment described in the statement of accepted facts, Dr. Conaty responded: “This is all the result of an aging process. It is my opinion that aggravation is not indicated as a result of an ongoing degenerative process.” He added that appellant’s nonindustrial disabilities were problems referable to the degenerative changes of the cervical spine and the rotator cuff tear on the right. Asked whether appellant continued to suffer residuals of her accepted injuries, Dr. Conaty stated: “She continues to suffer residuals, but not from the injury. I consider this all an aging ongoing process.”

In a decision dated March 16, 2007, the Office denied appellant’s claim of wage loss from July 17 to September 1, 2006. It noted appellant March 25, 2004 injury and the acceptance of strain/sprains of the shoulders, wrists and neck. Although Dr. Tooma diagnosed cervical discogenic disease and multilevel spondylosis with varying degrees of central and neural foraminal stenosis, the Office noted that he provided no medical rationale as to how factors of appellant’s federal employment contributed to the diagnosed condition. It also noted that Dr. Conaty felt appellant’s cervical condition was an ongoing degenerative problem related to aging and thus not related to the March 2004 employment injury. The Office denied appellant’s claim of compensation from July 17 to September 1, 2006 on the grounds that her physician’s medical rationale was not sufficient to establish that she was totally disabled for work due to the accepted conditions.

In a decision dated September 11, 2007, an Office hearing representative affirmed the denial of appellant’s claim for wage loss from July 17 to September 1, 2006. The hearing representative noted that the Office accepted appellant’s March 25, 2004 claim for bilateral rotator cuff strains, wrist strains and cervical strain. He noted that it appeared appellant’s ongoing disability had little or nothing to do with these accepted conditions. Although appellant had asked the Office to update her accepted conditions, the hearing representative found no basis to do so; there was no evidence that appellant’s cervical spondylosis or stenosis or carpal tunnel syndrome or degenerative conditions were in any way causally related to appellant’s federal employment. The hearing representative concluded that the medical evidence failed to establish that appellant was totally disabled from July 17 to September 1, 2006 due to the accepted work-related injury of March 25, 2004.<sup>4</sup>

### **LEGAL PRECEDENT**

The Federal Employees’ Compensation Act provides compensation for the disability of an employee resulting from personal injury sustained while in the performance of duty.<sup>5</sup> A claimant seeking benefits under the Act has the burden of proof to establish the essential

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<sup>4</sup> The hearing representative found that the sworn statement of Dr. Rodney D. Henderson established that he never released appellant to return to work in July 2005.

<sup>5</sup> 5 U.S.C. § 8102(a).

elements of her claim by the weight of the evidence,<sup>6</sup> including that she sustained an injury in the performance of duty and that any specific condition or disability for work for which she claims compensation is causally related to that employment injury.<sup>7</sup>

The evidence generally required to establish causal relationship is rationalized medical opinion evidence. The claimant must submit a rationalized medical opinion that supports a causal connection between her current condition and the employment injury. The medical opinion must be based on a complete factual and medical background with an accurate history of the claimant's employment injury, and must explain from a medical perspective how the current condition is related to the injury.<sup>8</sup>

While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence.<sup>9</sup> It must obtain any evidence that is necessary for the adjudication of the case which is not received when the notice or claim is submitted. The Office is responsible for providing the claimant information about the procedures involved in establishing a claim, including detailed instructions for developing the required evidence, and upon initial examination of the case should request all evidence necessary to adjudicate the case.<sup>10</sup> When the Office undertakes to develop the medical aspects of a case, it must exercise extreme care in seeing that its administrative processes are impartially and fairly conducted.<sup>11</sup>

### ANALYSIS

Appellant claimed compensation for total disability from July 17 to September 1, 2006. She therefore has the burden of proof to establish that she was totally disabled for work during this period as a result of her accepted employment injury. The Office has denied compensation for this period because the medical evidence did not establish that appellant was totally disabled as a result of her March 25, 2004 injury, which the Office accepted for various strains.

The Office also accepted a second employment injury in 2004. It accepted appellant's December 2, 2004 claim for lumbar sprain/strain, displacement of lumbar intervertebral disc without myelopathy, and thoracic or lumbar intervertebral disc degeneration. In its statement of accepted facts, the Office states that it accepted this claim for bilateral carpal tunnel syndrome, thoracic back strain/sprain, medial epicondylitis, right shoulder/rotator cuff strain/sprain,

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<sup>6</sup> *Nathaniel Milton*, 37 ECAB 712 (1986); *Joseph M. Whelan*, 20 ECAB 55 (1968) and cases cited therein.

<sup>7</sup> *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

<sup>8</sup> *John A. Ceresoli, Sr.*, 40 ECAB 305 (1988).

<sup>9</sup> *Mary A. Barnett (Frederick E. Barnett)*, 17 ECAB 187, 189 (1965).

<sup>10</sup> Federal (FECA) Procedure Manual, Part 2 -- Claims, *Development of Claims*, Chapter 2.800.3.c (April 1993).

<sup>11</sup> *William N. Saathoff*, 8 ECAB 769 (1956) (finding that the deficiency in the medical evidence adduced was attributable to the Office, then known as the "Bureau of Employees' Compensation").

displacement of cervical intervertebral disc without myelopathy, and displacement of lumbar intervertebral disc without myelopathy.

The Office consolidated these cases in March 2006. So when appellant claimed compensation for total disability from July 17 to September 1, 2006, the issue was not, as the Office adjudicated, whether she was totally disabled as a result of her March 25, 2004 employment injury. The issue was broader. The issue was whether she was totally disabled by either her March 25 or December 2, 2004 employment injuries. By considering only the first injury, the Office limited the issue to mere strains. But appellant also had accepted conditions that included disc displacement, disc degeneration and apparently bilateral carpal tunnel syndrome and medial epicondylitis. Indeed, the Office informed appellants' congressman that the accepted conditions included cervical disc syndrome, cervical radiculopathy, right rotator cuff sprain, bilateral shoulder impingement, bilateral carpal tunnel syndrome, bilateral medial epicondylitis, thoracic spine sprain, right knee sprain, displacement of the lumbar disc and lumbosacral radiculitis. These are the same diagnoses that Dr. Yee reported on April 27, 2004, when he offered medical rationale to support that appellant had a number of conditions that were causally related to the specific physical demands of her employment as a letter carrier.

Because the Office too narrowly adjudicated appellant's claim for wage loss, the Board will set aside the Office's March 16 and September 11, 2007 decisions and remand the case for further development and adjudication. The medical management of this case became complex after the Office's initial acceptance of simple strains on July 1, 2004, so the Office must first clarify what medical conditions it has accepted as causally related to appellant's federal employment. If the Office accepts that Dr. Yee presented sound medical rationale to establish that his 10 diagnoses are causally related to the duties appellant performed as a letter carrier, it must include those medical conditions in its statement of accepted facts. It should also determine whether Dr. Dunlap and Dr. Tooma presented sufficient medical reasoning to establish that the conditions they diagnosed were caused or aggravated by repetitive, cumulative trauma in the course of appellant's federal employment. If so, the Office should identify those diagnoses as accepted conditions. Further, it should amend the statement of accepted facts to include a detailed description of the physical demands of appellant's position, similar to the details Dr. Yee provided. This will help to give any referral physician a proper factual background upon which to render an opinion on appellant's claim for compensation.

Having sought a second opinion, the Office has the responsibility to obtain an evaluation that will resolve the issue involved in the case.<sup>12</sup> The Board finds that Dr. Conaty's opinion is insufficient because the statement of accepted facts was lacking, because he did not offer sound medical reasoning, and because he did not address the issue of disability for the specific period claimed. After clarifying the accepted conditions and amending the statement of accepted facts, the Office shall further develop the medical opinion evidence to determine whether appellant was totally disabled for work from July 17 to September 1, 2006 as a result of her accepted medical

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<sup>12</sup> *Mae Z. Hackett*, 34 ECAB 1421, 1426 (1983); *see also Milton Lehr*, 45 ECAB 467 (1994) (where the Board remanded the case to the Office for a medical opinion, and the opinion obtained from the attending physician was not sufficient to resolve the issue, the Board found that the Office should obtain a supplemental report from the attending physician curing the deficiency and resolving the issue in the case).

conditions. The Office shall then issue an appropriate final decision on appellant's entitlement to compensation for wage loss during the period of disability claimed.

**CONCLUSION**

The Board finds that this case is not in posture for decision. Further development of the evidence is warranted.

**ORDER**

**IT IS HEREBY ORDERED THAT** the September 11 and March 16, 2007 decisions of the Office of Workers' Compensation Programs are set aside. The case is remanded for further action consistent with this opinion.

Issued: August 12, 2008  
Washington, DC

David S. Gerson, Judge  
Employees' Compensation Appeals Board

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

James A. Haynes, Alternate Judge  
Employees' Compensation Appeals Board