U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of PATRICIA A. MITCHELL and U.S. POSTAL SERVICE,
POST OFFICE, Denver, CO

Docket No. 02-1372; Submitted on the Record;
Issued February 12, 2003

DECISION and ORDER

Before COLLEEN DUFFY KIKO, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issue is whether appellant sustained an injury to her left upper extremity as a result of her modified-duty assignment.

In this case, the Office of Workers' Compensation Programs accepted, in separate file numbers, that appellant sustained right lateral epicondylitis[1] and a left knee strain with an approved subsequent surgery on September 10, 1997.[2] As a result of such work-related conditions appellant has been working in a modified distribution clerk position with permanent restrictions on the use of her right arm.[3]

On July 20, 2000 appellant filed an occupational disease claim for her left hand and arm conditions, which she alleged, resulted from her modified distribution clerk position on or about July 10, 2000. She stated that she had been working as a modified distribution clerk for the last five years, since she sustained permanent injury to her right arm and hand. Appellant noted that she uses her right arm intermittently, but mainly uses her left arm and hand to grasp, retrieve and throw letter mail. She further noted that she had a 20-pound weight restriction.

In a decision dated October 27, 2000, the Office denied appellant's occupational claim on the basis that the medical evidence was insufficient to establish a causal relationship to her employment factors. Following an oral hearing held at appellant's request, in a decision dated March 27, 2001, an Office hearing representative set aside the previous decision and remanded the case for a *de novo* decision. The hearing representative found the case was not in posture for

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[1] File No. A12-0155652. The date of injury for appellant's right hand and arm condition is July 14, 1995.

[2] File No. A12-0169403. The date of injury for appellant's left knee strain is March 29, 1997.

[3] In a decision issued February 9, 2001, the Board affirmed the Office's decisions of December 16 and 9 and November 16 and 2, 1998, which concerned issues pertaining to overpayment and a schedule award for loss of use of the left leg. (Docket Nos. 99-859 and 00-2501).

decision on the basis that although the newly submitted medical evidence was insufficient to meet appellant's burden of proof to establish a causal relationship, the Office was obligated to further develop the claim prior to adjudicating it.

On remand, the Office referred appellant, along with a statement of accepted facts, a copy of her position description, a list of questions and the medical record, to Dr. Richard D. Talbott, a Board-certified orthopedic surgeon, for a second opinion evaluation. In a report dated June 19, 2001, Dr. Talbott noted the history of injury, appellant's medical history and treatment of her left arm and set forth his examination findings. Dr. Talbott stated that he was unable to render any orthopedic diagnosis. He specifically opined that appellant does not have epicondylitis or de Quervain's disease. Dr. Talbott advised there were no abnormal objective findings on examination. He further stated that although appellant may have had some symptoms, it was perhaps related to fatigue. Dr. Talbott opined that there was no physical reason why appellant could not perform her usual duties with no restrictions.

By decision dated June 28, 2001, the Office denied appellant's claim on the basis that the medical evidence failed to establish that the claimed condition was either caused or aggravated by appellant's employment. Determinative weight was given to the opinion of Dr. Talbott, the Office referral physician.

Appellant, through her attorney of record, requested a hearing, which was held December 6, 2001. Submitted was a copy of appellant's job description along with the following medical evidence.

In a July 19, 2000 report, Dr. Lawrence N. Varner, an orthopedic surgeon, noted appellant's history of injury and provided an impression of left elbow mild lateral epicondylitis. On examination, appellant exhibited lateral epicondylar tenderness, left elbow, to palpation. She had full prone and supination and flexion/extension in the elbow and wrist extension against resistance pulled and increased the pain at the lateral epicondyle, left elbow. However, forced supination against resistance did not increase her lateral left elbow pain. Numbness was noted over the sensory branch of the radial nerve, left thumb webspace and percussion along the branch of the nerve shows a positive Tinel's. She had a negative Tinel's over the carpal tunnel. Appellant has a negative Finkelstein maneuver, performed because of some vague description of discomfort about the thumb base. Negative grinding test, left thumb. The remainder of her upper extremity examination was unremarkable. He opined that appellant could continue working, with the 20-pound weight restriction.

In a progress note dated October 12, 2000, Dr. Cynthia M. Kelly, a Board-certified orthopedic surgeon and appellant's treating physician, noted appellant was still having pain in the region of the lateral epicondyle of her left elbow. Physical examination revealed persistent tenderness on palpation of the lateral epicondyle with mild exacerbation of her symptoms with resistive wrist extension and no complaints of pain with resisted extension of her middle finger. Repeat corticosteroid injections and wearing of the tennis elbow strap was recommended. In a September 19, 2000 report, Dr. Kelly stated that appellant's left shoulder pain was most likely due to mild rotator cuff tendinitis. Left elbow pain was attributable to lateral epicondylitis and left wrist pain was consistent with mild de Quervain's tenosynovitis.

In a May 15, 2001 medical report, Dr. Kelly advised that appellant has been evaluated and treated for a lateral epicondylitis. Based on appellant's previous right upper extremity injury and her ongoing complaints in her left upper extremity, Dr. Kelly opined that appellant's symptoms were consistent with the job injury as described by her. After reviewing the position description and exertional requirements of the job, Dr. Kelly stated that appellant's symptoms were consistent with repetitive motion activity injuries. She noted that with regard to injuries that are attributed to repetitive motions, rest is one of the prescribed treatment modalities; however, appellant was limited with regard to use of her right upper extremity, therefore, putting more exertion and stress on her left upper extremity.

In a May 21, 2001 medical report, which the Office received in October 2001, Dr. Yechiel Kleen, Board-certified in physical medicine and rehabilitation, noted appellant's previous work injuries concerning her left knee and right arm. Strength was noted to be 5/5 in all 4 extremities throughout. Sensory for light touch and pinprick was intact for all four extremities throughout. Deep tendon reflex was 2/4 in all 4 extremities throughout with downgoing toes, bilaterally. Tinel's test was negative bilaterally in the elbows and wrists. Appellant had a 90-degree bilateral straight leg raise in the sitting position. Gait was within normal limits, including heel and toe gait. The left knee exhibited limited flexion and extension with tender palpation over the left knee joint. No muscle atrophy was noted in the upper and lower extremities, bilaterally. With regard to appellant's left arm conditions, Dr. Kleen opined that appellant had bilateral upper extremity cumulative trauma disorder and needed to rule out compression neuropathy with electromyography (EMG) and nerve conduction studies (NCS) of the upper extremities bilaterally.

In a June 29, 2001 medical report, Dr. Kleen advised that bilateral upper extremity EMG/NCS were performed on June 19, 2001. With regard to appellant's left upper extremity, Dr. Kleen opined that clinically appellant has bilateral ulnar neuropathies. Right side was related to the May 1995 injury. Left side related to the 2000 injury. Copies of the EMG/NCS were provided.

In a July 18, 2001 medical report, Dr. Kleen continued to report that, clinically, appellant has left-sided ulnar neuropathy of the elbow.

By decision dated February 26, 2002, an Office hearing representative found the newly submitted evidence and arguments to be insufficient to warrant modification of the prior decision. The instant appeal follows.

The Board finds that appellant has not met her burden of proof to establish that she sustained an injury to her left upper extremity as a result of her modified-duty assignment.

When an employee, who is disabled from the job she held when injured on account of employment-related residuals, returns to a light-duty position or the medical evidence of record establishes that he or she can perform the light-duty position, the employee has the burden to establish by the weight of the reliable, probative and substantial evidence a recurrence of total disability and show that she cannot perform such light duty. As part of this 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.[4] This burden includes the necessity of furnishing evidence from a qualified physician who, on the basis of a complete and accurate factual and medical history, concludes that the condition is causally related to the employment injury and supports that conclusion with sound medical reasoning.[5] Causal relationship is a medical issue[6] and the medical evidence required to establish a causal relationship is rationalized medical evidence. Rationalized medical evidence is medical evidence, which includes a physician's rationalized medical 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.[7]

In the present case, appellant does not allege a change in the nature and extent of the light-duty job requirements. She just attributes the fact that her right arm restrictions have caused added stress to her left arm activities, which required repetitive motion. Appellant's testimony along with the record shows that she returned to work in a limited-duty capacity with certain work restrictions as a result of an accepted right hand and arm condition. The record does not establish that appellant's current left hand and arm conditions were caused by a change in the nature or extent of the light-duty job requirements.

In this case, the medical reports from appellant's treating physicians, with the exception of the May 15, 2001 report of Dr. Kelly, fail to offer a well-rationalized medical opinion explaining how or why appellant's left hand and arm conditions arose out of or were affected by her light-duty job requirements. Although Dr. Varner diagnosed left elbow mild lateral epicondylitis and noted a positive Tinel's test over the sensory branch of the radial nerve in his July 19, 2000 report, he failed to offer an opinion on causation and, thus, his report is not probative. Although Dr. Kleen opined that "clinically" appellant has a left-sided ulnar neuropathy of the elbow which was "related to the 2000 injury," he failed to offer an opinion as to how or why appellant's left arm condition developed specific to her situation.[8] Moreover, Dr. Kleen failed to explain what a "clinical" neuropathy was and distinguish or compare this to his June 19, 2001 findings on the NCS and EMG which were reported to be normal for the left upper extremity. Accordingly, his opinion is not probative. Although Dr. Kelly attributed the conditions of epicondylitis and de Quervain's disease to appellant's repetitive motion activities and the fact that appellant was putting more exertion and stress on her left upper extremity as a result of restrictions placed on the use of her right upper extremity, her reports are not probative

[4] *George DePasquale,* 39 ECAB 295 (1987); *Terry R. Hedman,* 38 ECAB 222 (1986).

[5] *Frances B. Evans*, 32 ECAB 60 (1980).

[6] *Mary J. Briggs*, 37 ECAB 578 (1986).

[7] *Gary L. Fowler*, 45 ECAB 365 (1994); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[8] *See Durwood H. Nolin*, 46 ECAB 818, 821-22 (1995).

because they are not based on any objective evidence. The only objective finding was the subjective complaint of tenderness on palpation of the lateral epicondyle.

In his June 19, 2001 report, Dr. Talbott, a Board-certified orthopedic surgeon and Office referral physician, specifically stated that there were no abnormal objective findings on examination and he was unable to render any orthopedic diagnosis. He further stated that appellant did not have epicondylitis or de Quervain's disease and advised that although she may have had some symptoms, it was perhaps related to fatigue. As such, Dr. Talbott's June 19, 2001 report provides a well-rationalized medical opinion that appellant has not sustained an injury to her left hand or arm as a result of her modified position and represents the weight of the medical evidence in this case.

The decision of the Office of Workers' Compensation Programs dated February 26, 2002 is affirmed.[9]

Dated, Washington, DC
February 12, 2003

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

[9] It appears that appellant filed a recurrence claim and submitted evidence subsequent to the Office's February 26, 2002 decision. The Board does not have jurisdiction to review evidence submitted by appellant subsequent to the Office's February 26, 2002 decision. The Board cannot review this evidence on appeal, as the Board's jurisdiction is limited to reviewing the evidence and arguments that were before the Office at the time of its final decision; *see Lloyd E. Griffin, Jr.*, 46 ECAB 979 (1995); *Carroll R. Davis*, 46 ECAB 361 (1994). Appellant may submit such evidence to the Office along with a request for reconsideration if desired.