U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of ANTOINETTE CUNDIFF and U.S. POSTAL SERVICE,
POST OFFICE, Chicago, IL

Docket No. 02-1809; Submitted on the Record;
Issued May 27, 2003

DECISION and ORDER

Before ALEC J. KOROMILAS, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issues are: (1) whether the Office of Workers' Compensation Programs properly terminated appellant's compensation benefits for the condition of bilateral shoulder bursitis effective December 29, 2000; (2) whether appellant is entitled to a schedule award; and (3) whether the Office properly denied appellant's claim for wage loss for the period December 1, 1995 to November 27, 1997.

On June 29, 1998 appellant, then a 32-year-old mailhandler, filed an occupational disease claim alleging that excessive lifting and standing in the course of her employment, as well as throwing bags and boxes over her head into a bulk mail container, injured her shoulders, neck, elbows and hands and caused headaches and back pain. She first became aware of this condition in December 1995 and first realized, at that time, that this condition was caused or aggravated by her employment.

The Office assigned this claim to File Number A10-0499572. The case file also contains records relating to a previous claim, File Number A10-0450658, wherein the door of a bulk mail container struck her on the head on December 11, 1995. Appellant stopped work on December 14, 1995 and did not return.

On June 30, 2000 appellant explained to the Office:

> "I am writing you to inform you that I was never accepted for the other work-related injuries that occurred during my employment at the [employing establishment]. I suffered a head injury, shoulder injury and tendinitis of the elbow and hand. I was only accepted for the neck injury in the claim # 1000450658. The other injuries sustained were never accepted and I continue to suffer from these injuries. I have included the medical records that I have for treatment in 1998 [through] 2000. I cannot get the consistent medical treatment I need because I have no insurance to pay for the treatment that the [employing establishment] is suppose to pay. The injuries I received at the [employing establishment] will be with me for the rest of my life. The pain is a daily pain, which makes it a weekly pain and surely it has

been and is yearly pain. I am in the process of getting the information from the Social Security doctors on their findings and also their administrative judges findings."

Appellant submitted medical reports from Dr. Choong J. Yoon, a specialist in physical medicine and rehabilitation. Dr. Yoon first evaluated appellant on January 4, 1996. Appellant complained of severe neck and upper back pain in the bilateral cervical and upper trapezius muscles, left worse than right, constant and sharp in nature but without radiation. She complained of numbness and tingling in both upper arms, especially around the elbow. Appellant also complained of headaches. Cervical range of motion was severely limited, with severe tenderness in both upper trapezius muscles and posterior neck muscles and with severe muscle spasms. Dr. Yoon diagnosed cervical sprain/strain and post-traumatic headache. Because appellant was having a slow response, Dr. Yoon recommended physical therapy. He ordered cervical and thoracolumbar spine x-rays as well as a brain and cervical spine magnetic resonance imaging (MRI) scan to confirm any injury. Dr. Yoon reported that appellant was unable to work.

By February 5, 1996 appellant's complaints included radiating pain and numbness in both extremities. She also complained of a deep, aching type of left shoulder pain with elevation of the left arm. Dr. Yoon ordered a repeat MRI of the cervical spine and ordered continuing physical therapy. He reported that appellant would not return to work.

On June 3, 1996 Dr. Yoon noted some progress. He stated that the MRI scans of the cervical spine and brain were normal. Dr. Yoon diagnosed post-traumatic headache and bilateral lateral epicondyle tendinitis. He ordered an electromyogram (EMG) and nerve conduction studies.

On June 24, 1996 Dr. Yoon reported that the EMG findings were normal with no radiculopathies noted. Appellant noted that overall her pain was better and her mobility improved, but that she still had stiffness in her neck and still experienced daily headaches. She complained of stabbing pains in both shoulders and arms, including the elbows. Appellant had two injections to the upper trapezius muscles and continued physical therapy.

On October 21, 1996 Dr. Yoon noted that appellant had demonstrated a lack of progress in the physical therapy program. He referred appellant to a chiropractor and discharged her from care.

Appellant returned to Dr. Yoon on December 9, 1996. Her pain was still severe and was located in the paracervical and upper trapezius muscles, 4-5/5, constant, sharp, aching and tingling. Appellant had headaches on a daily basis associated with neck muscle spasm. She also complained of bilateral elbow pain. Physical examination was unchanged.

On February 21, 1997 Dr. Yoon noted that appellant had been seen in the emergency room a few times since her last visit, most recently on February 20, 1997 due to severe pain in her left upper trapezius muscles and left shoulder. He related that this pain was ongoing and had worsened since he released appellant. Range of motion was severely limited, with tenderness, tightness and mild crepitation. Dr. Yoon diagnosed bilateral shoulder tendinitis, supraspinatus muscle, possible left rotator cuff tear, frozen shoulder, chronic cervical strain and sprain, bilateral lateral epicondylitis and fibrositis.

An MRI scan report dated February 26, 1997 diagnosed no definite tear of the left rotator cuff but mild impingement syndrome with mild pressure on the rotator cuff by the mild hypertrophy of the acromioclavicular joint.

Appellant came under the care of Dr. H. Carl Moultrie, II, an orthopedist, who reported on November 30, 1998 that appellant's left shoulder had been getting progressively more painful since 1995. Pain radiated across the shoulder, across the neck and into the right shoulder. After reporting his findings on examination, Dr. Moultrie diagnosed impingement syndrome of the left shoulder, status post cervical strain and heel spur. He stated: "We have absolutely no medical reports, x-rays, or anything to indicate any significant medical treatment. We will need to get the MRI [scan] report and records from Dr. Yoon."

An arthrogram on December 15, 1998 was reported to be essentially normal without evidence of a rotator cuff tear. Some spurring along the inferior aspect of the acromion process was noted incidentally. Dr. Moultrie reported on February 12, 1999: "We must see Dr. Yoon's notes, her previous x-rays, MRI scan, arthrogram and x-rays of the neck before we can adequately evaluate the patient."

On July 21, 2000 the Office accepted appellant's occupational disease claim for the condition of bilateral shoulder bursitis.

On July 24, 2000 appellant filed a claim for a schedule award.

On August 10, 2000 appellant filed a claim for wage loss for the period December 1, 1995 to November 27, 1997.[1]

On December 8, 2001 the Office advised appellant that she must submit medical evidence supporting total disability for the period December 1, 1995 to November 27, 1997.

The Office referred appellant, together with the medical record and a statement of accepted facts, to Dr. Hilliard E. Slavick, a neurologist, and Dr. Leonard R. Smith, an orthopedist, for an opinion on the nature and extent of her work-related disability and impairment.

On November 12, 2000 Dr. Slavick reported that he had reviewed appellant's medical records and her job description. He related her injury in December 1995, when the door of a bulk mail container struck her in the head and described her subsequent medical treatment. After reporting his findings on examination, Dr. Slavick offered the following opinion:

> "It is my impression that she is status post head trauma on December 11, 1995. Her subsequent development of shoulder and elbow tendinitis, in my opinion, would not be related to such an injury. It would be expected that she would have headaches and dizziness related to a rather mild head injury without loss of consciousness for a period of 6 [to] 12 weeks at a maximum. This should then resolve. She appears to be voluntarily restricting motion in her left arm during the exam[ination]. When

[1] The record shows that appellant received compensation from January 31 to November 19, 1996 under the prior claim relating to her traumatic injury on December 11, 1995. Also, the record indicates that the Office terminated appellant's compensation under the prior claim in a decision dated November 22, 1996. The Office found that disability related to her December 11, 1995 injury ceased by that date.

observed without her knowledge and when removing her shoes and bending and moving forward, she moved the arm (left) in a normal fashion. I find no evidence of any focal neurological deficits to explain her somatic complaints. She thus has subjective complaints with no objective findings. I feel she has completely resolved her neurological symptoms. At this time, she has no objective neurologic findings. I do not believe that the shoulder bursitis present bilaterally and more so on the left would be explained by the work-related incident of December 11, 1995. She does not appear at this time to have any work-related condition. She is able to return to work in her normal duty job. I have reviewed her job description. She does not need further medical care in my opinion. I do not feel she needs work hardening or further physical therapy. I believe that her work-related injury should have resolved within 6 to 12 weeks. She has reached maximum medical improvement. She can perform her regular work duties without restrictions."

Dr. Slavick completed a work capacity evaluation on November 11, 2000 indicating that appellant could work normal duty eight hours a day without limitation.

In a supplemental report to the Office dated November 18, 2000, Dr. Slavick addressed the issue of bilateral shoulder bursitis as follows:

"I did not address the issues of bilateral shoulder bursitis because that is an orthopedic problem that has been previously evaluated. As a neurologist, I do not evaluate that condition. I did address the issue of her cervical strain and complaints related to it. I found no evidence of neurologic dysfunction. Based on my neurologic exam[ination], she is able to work at normal duty. Measurements of impairment of the shoulder joint would have to be performed by an orthopedic surgeon. As I described in my report, she appears to be voluntarily restricting motion in her left arm. I also stated that I did not believe that her shoulder bursitis would be explained by the work-related incident of December 11, 1995. I, thus, would not grade her based on A[merican] M[edical] A[ssociation], *Guides to the Evaluation of Permanent Impairment*]. Please refer her to an orthopedic surgeon for an update concerning questions you related in your letter of November 16, 2000."

On December 29, 2000 Dr. Smith reported that he examined appellant that day and reviewed her records. He related her history, medical treatment and current complaints. Dr. Smith described his findings on physical examination. He reported:

"Current diagnostic condition is possible cervical sprain and/or shoulder sprain recovered, without evidence of any objective findings. She may have incurred also a contusion to her head with no residual findings. I do not find any evidence of a bilateral shoulder bursitis. At this time, it is impossible to state at what point she will actually resume her regular work activities; however, based upon today's examination, she is fully capable of performing any work activities she may choose to do, and does not require any further medical treatment having reached maximum medical improvement and that she can perform the duties as described in [the statement of accepted facts]. It is also noteworthy that, during this period of time, she was treated with Elavil, Zoloft and other drugs which are normally given for

depression, because the need for these would not have been related to the incident in question."

In a supplemental report dated February 1, 2001, Dr. Smith stated:

"Pursuant to your request for supplementary information regarding permanent disability regarding the accepted injuries on [appellant] which have been previously described, I have reviewed the reports and estimate that she has sustained a zero loss of usage of her upper extremities based upon utilizing the A.M.A., *Guides*, [f]ourth [e]dition, since there is no restriction of motion with regard to usage of the extremities."

On July 25, 2001 the Office issued a notice of proposed termination of medical benefits and entitlement to compensation payments. The Office found that the weight of the medical evidence rested with the reports of Drs. Slavick and Smith, which showed no objective findings to support subjective complaints and which established that appellant was capable of performing her work without restrictions.

In a decision dated December 8, 2001, the Office terminated appellant's medical benefits and entitlement to compensation payments as of December 29, 2000. The Office also denied appellant's claim for a schedule award.

In a decision dated March 16, 2002, the Office denied appellant's claim for wage loss for the period December 1, 1995 to November 27, 1997. The Office found that the record contained no medical evidence to support total disability for the period claimed.

The Board finds that the Office properly terminated appellant's compensation benefits for the condition of bilateral shoulder bursitis effective December 29, 2000.

It is well established that once the Office accepts a claim, it has the burden of proof to justify termination or modification of compensation benefits.[2]

Appellant filed an occupational disease claim on June 29, 1998 alleging that excessive lifting and standing in the course of her employment, as well as throwing bags and boxes over her head into a bulk mail container, injured her shoulders, neck, elbows and hands and caused headaches and back pain. On July 21, 2000 the Office accepted this claim for the condition of bilateral shoulder bursitis. The Office terminated appellant's medical benefits and entitlement to compensation payments as of December 29, 2000, and therefore has the burden of proof to justify this termination.

Reports from Dr. Slavick, the Office referral neurologist, in November 2000 are not particularly probative on whether appellant continued to suffer residuals of the accepted bilateral shoulder bursitis. He explained that he did not address the issue of bilateral shoulder bursitis because that was an orthopedic problem. As a neurologist, he did not evaluate that condition. Dr. Slavick advised the Office to refer appellant to an orthopedic surgeon.

[2] *Harold S. McGough*, 36 ECAB 332 (1984).

The Office's termination of compensation therefore rests on the reports of Dr. Smith, the Office referral orthopedist, who examined appellant on December 29, 2000 and found no evidence of bilateral shoulder bursitis. Appellant's current diagnostic condition was possible cervical sprain and/or shoulder sprain recovered, with no evidence of objective findings. Dr. Smith explained that, based upon his examination of appellant, she was fully capable of performing any work activities she might choose to do. She required no further medical treatment and could perform the duties of a mailhandler as described in the statement of accepted facts.

Dr. Smith's opinion is based on an accurate factual and medical history. It is unequivocal and is sufficiently well reasoned to establish that appellant had no evidence of bilateral shoulder bursitis on December 29, 2000 and no current disability for the position of mailhandler as a result of such a condition. There is no contemporaneous medical opinion evidence to the contrary. The Board finds, therefore, that Dr. Smith's opinion represents the weight of the medical evidence and is sufficient to discharge the Office's burden of proof to justify the termination of compensation benefits for the condition of bilateral shoulder bursitis. The Board will affirm the Office's December 8, 2001 decision on the issue of termination.

The Board also finds that appellant is not entitled to a schedule award.

Section 8107 of the Federal Employees' Compensation Act provides that, if there is permanent disability involving the loss or loss of use of a member or function of the body, the claimant is entitled to a schedule award for the permanent impairment of the scheduled member or function.[3]

On July 24, 2000 appellant filed a claim for a schedule award. She, therefore, has the burden of proof to establish that she sustained a permanent impairment of a scheduled member or function of the body as a result of the accepted bilateral shoulder bursitis.

As the weight of the medical evidence establishes no evidence of bilateral shoulder bursitis by December 29, 2000, there is no basis for permanent impairment. Further, Dr. Smith reported in his supplemental report of February 1, 2001 that appellant had no restriction of motion with regard to the usage of her extremities and therefore had no impairment. The record contains no medical opinion to the contrary. Appellant has not met her burden of proof. The Board will affirm the Office's December 8, 2001 decision on the issue of permanent impairment.

The Board also finds that the Office properly denied appellant's claim for wage loss for the period December 1, 1995 to November 27, 1997.

A claimant seeking benefits under Act has the burden of proof to establish the essential elements of her claim by the weight of the evidence,[4] 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.[5]

[3] 5 U.S.C. § 8107(a).

[4] *Nathaniel Milton*, 37 ECAB 712 (1986); *Joseph M. Whelan*, 20 ECAB 55 (1968) and cases cited therein.

[5] *Elaine Pendleton*, 40 ECAB 1143, 1145 (1989).

The Office accepted that appellant sustained a bilateral shoulder bursitis in the performance of duty. It is appellant's burden to establish that any wage loss for the period claimed is causally related to that condition. As part of her burden, appellant must submit rationalized medical opinion evidence based on a complete factual and medical background showing causal relationship.[6]

Appellant submitted no such evidence. Although Dr. Yoon reported as early as January 4, 1996 that appellant was unable to work, he did not report that appellant was disabled for work from December 1, 1995 to November 27, 1997 as a result of bilateral shoulder bursitis. When appellant came under the care of Dr. Moultrie, he explained that he could not adequately evaluate appellant without Dr. Yoon's notes and appellant's previous diagnostic studies. Dr. Moultrie offered no opinion on the cause of disability for the period claimed.

Because appellant has not met her burden of proof to establish that her disability for work during the period December 1, 1995 to November 27, 1997 was a result of bilateral shoulder bursitis, the Board will affirm the Office's March 16, 2002 decision.

The March 16, 2002 and December 8, 2001 decisions of the Office of Workers' Compensation Programs are affirmed.

Dated, Washington, DC
May 27, 2003

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

[6] *Tracey Smith-Cashen*, 38 ECAB 568, 572-73 (1987).